Commonwealth of Massachusetts
Executive Office of Elder Affairs

State Plan on Aging

Federal Fiscal Years 2010 – 2013

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EXECUTIVE OFFICE OF ELDER AFFAIRS
Promoting Your Independence

Massachusetts Elder Information Resources

Telephone Numbers

Agency Main Telephone Number ……..……..1-617-727-7750

Agency Toll Free Number …..…1-800-AGE-INFO (1-800-243-4636)

Elder Abuse Hotline ……..……1-800-922-2275 (V/TDD)

Protective Service Programs ……..……..1-617-727-7750

Agency TDD/TTY ……..……..1-800-872-0166

Prescription Advantage ...1-800-243-4636 or 1-877-610-0241 (TTY)

Agency Facsimile Number ……..……..1-617-727-9368

Website Links

Executive Office of Elder Affairs……...…..…www.mass.gov/elder

800AGEINFO….……..……www.800ageinfo.com

Executive Office of Health and Human Services ……...……..www.mass.gov/eohhs

Commonwealth of Massachusetts Official Website ……www.mass.gov

Massachusetts Councils on Aging ……www.mcoaonline.com

Federal Administration on Aging ……..www.aoa.gov

Massachusetts State Plan on Aging - Contents

Setting a Framework for Services

The Massachusetts Executive Office of Elder Affairs (Elder Affairs) salutes the more than one million Massachusetts residents, sixty and older, who enrich our lives and bring stability and continuity to our communities. Today's seniors live healthier, longer lives, with many continuing to work or volunteer well beyond 65. Seniors are caring for parents, husbands, wives, friends, siblings and neighbors, as well as raising their grandchildren. Elder Affairs presents the Massachusetts State Plan on Aging 2010 – 2013 as a resource for offering services and programs that promote and extend seniors' independence, dignity, health and fulfillment.

Designing the Framework

Elder Affairs is charged with mobilizing the human, physical and financial resources to plan, develop and implement innovative programs to insure the dignity and independence of older persons. Elder Affairs' adherence to these fundamental principles continues today as we develop new programs and policies that allows us to advance our mission.

> **"Promote the independence and well-being of individuals, their families, and caregivers through the development and delivery of quality services. Provide consumers with access to a full ar ray of health and social support services in the settings of their choice. Inform consumers about their options and protective and advocacy services. Encourage individuals across the lifespan to adopt behaviors that will lead to healthy aging."**

Through a statewide network of Elder Services providers, Elder Affairs provides services locally via Area Agencies on Aging (AAA), Aging Services Access Points (ASAP), Councils on Aging (COA) and senior centers in communities across the Commonwealth. The network performs a wide range of functions including advocacy, planning, coordination, inter-agency linkages, information sharing, brokering, and monitoring and evaluation toward the goal of developing and enhancing comprehensive and coordinated community based sy stems for serving elders.

Today, Elder Affairs and the elder network direct services to nearly 46,200 elders through state funded Home Care Services, provide s more than 8.8 million congregate and home delivered meals to elders, serve s 230,000 service unit s of Information and Referral to elder s, caregivers and the public, and resolved more than 9,200 complaints from residents in nursing and rest homes. In addition Elder Affairs manages long-term care services provided to eligible MassHealth members of all ages that cover three main areas: Community Services, Coordinated Care Systems and Institutional, Residential and Day Services. Elder Affairs also administers Title III and Title VII social and nutrition services under the Older Americans Act, and fulfill s advocacy, planning, and policy functions on behalf of the 1. 2 million elders in the Commonwealth.

The Executive Office of Elder Affairs and those involved in the elder network are passionate about their work to allow all people to age with independence and dignity. Elder Affairs

holds steadfast to its mission of promoting the integrity, rights and independence of all seniors and their caregivers.

Older Americans Act of 1965, Direction and Guidance

Title III Programs originated within the Older Americans Act (OAA) of 1965, bringing focus and coherence to a national response to the needs of elder Americans. Title III of the OAA, as amended, authorizes funding and provides parameters for the operation of programs addressing the entire spectrum of elders' needs through in-home and community-based initiatives. Though special emphasis is placed on elders with particular economic or social needs, all Americans over age 60 may benefit from OAA and Title III programs. Additionally, caregivers of elders age 60 and over may also receive OAA support through the National Family Caregiver Support Program.

Federal Fiscal Year 2009 Older Americans Act funding was awarded to Elder Affairs in the following eight distinct categories:

OAA Funding Category	Federal FY 2009 Award
Title III-B Supportive Services	$8.2 mil
Title III-D Preventive Health	$.5 mil
Title III-C1 Congregate Meals	$9.9 mil
Title III-C2 Home Delivered Meals	$4.6 mil
Title III-E Family Caregiver Services	$3.4 mil
Title VII Elder Abuse Services	$.1 mil
Title VII LTC Ombudsman Services	$.3 mil
Nutrition Services Incentive Program	$4.3 mil

Elder Affairs, as the designated State Unit on Aging (SUA) in Massachusetts, is responsible for representing elders in the Commonwealth and advancing programs and services that address this population. In this role, Elder Affairs designs and implements a State Plan on Aging that communicates the course for serving home and community-based services to elders and caregivers in Massachusetts. The office is responsible for addressing existing demand for services as well as identifying emerging issues and options to prepare for the shift in demographics resulting from the aging of the Baby Boomer generation.

Goals to Action, 2010 – 2013

As the Federal agency that provides direction and guidance to Elder Affairs, the US Administration on Aging (AoA) has published a Strategic Action Plan for 2007-2012 that identifies priorities for continuing its work in promoting the dignity and independence of older people and in helping society prepare for an aging population. In its effort to direct the development of a comprehensive and coordinated system of care for older people, AoA has identified a vision that embraces the following goals:

1. Empower older people, their families, and other consumers to make informed decisions about, and to be able to easily access, existing health and long-term care options.
2. Enable seniors to remain in their own homes with high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers.
3. Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare.
4. Ensure the rights of older people and prevent their abuse, neglect and exploitation.

The Executive Office of Elder Affairs, as directed by the Community First policy goals of supporting elders and people with disabilities to remain in or return to community living, is guided by goals with accompanying objectives. Elder Affairs' goals builds a framework to develop programs and services that continue our efforts to ensure the elder network in Massachusetts develops and manages comprehensive and coordinated community-based systems for serving elders. The four goals that guide Elder Affairs mission are based on our strategic plan and include:

1. Building greater capacity in home and community-based services and settings.
2. Improving access to services.
3. Promoting financial well-being and healthy aging.
4. Expanding and strengthen collaborations and partnerships across public and private sectors.

State Plan on Aging, 2010 – 2013

The State Plan on Aging 2010-2013 encompasses activities for the next four Federal Fiscal Years and provides a staging for policies and programs in support of a comprehensive and coordinated system for servicing elders in the Commonwealth. The State Plan and the AoA strategic goals provide a framework for shaping the policy development, administration, coordination, priority setting, and evaluation of State activities related to the objectives of the Older Americans Act. Given the projected growth in the aging population over the next few decades, the administration is committed to finding more effective approaches to providing long-term supports that efficiently respond to the needs and preferences of elders.

In setting a framework for providing services under the Older Americans Act that builds greater capacity for home and community-based services, Elder Affairs' vision reveals our promise and passion for serving elders.

> **"Empower individuals to make their own choices based upon their preferences and desires. Encourage individuals to make a plan for achieving and sustaining quality of life goals, including aging in place with dignity, financial well-being and healthy aging."**

2009 Statewide Needs Assessment Study Review

Overview

Past preparation for four-year State Plans on Aging, included the Executive Office of Elder Affairs gathering information about elders' needs through a statewide needs assessment questionnaire. Since 1993, a 4-page survey, developed in collaboration with the 23 Area Agencies on Aging (AAAs), has been mailed to a random sample of approximately 11,000 elders across the Commonwealth. Completed surveys were returned to Elder Affairs with findings summarized and disseminated to the AAAs for incorporation in their respective Area Plans.

For the 2009 Needs Assessment study, instead of inquiring about 31 specific service needs, service needs were classified under 16 headings (areas of concerns) and incorporated concepts from "livable communities for all ages" and service areas listed in the Older Americans Act. The perspective for the areas is that all are interconnected during one's life span and no area more critical than another. However, since breakdowns occur along a person's life span (e.g., job loss, illness) certain areas surface , requiring attention and assistance.

The 16 areas of concern are classified under the following headings:

- Career/employment
- Education/learning
- Family/caregiver/support networks
- Financial security (money/finances)
- Food and nutrition
- Health care
- Housing/home ownership
- Legal assistance
- Leisure, recreation and physical activities
- Long-term care
- Maintain independence/dignity
- Mental health
- Transportation/personal mobility
- Safety and Security (personal/public)
- Spirituality
- Volunteer/civic engagement

Gathering information directly from elders about their concerns and needs was decentralized through the AAAs in contrast to the centralized system used in past studies. The questionnaires used to garner information from the providers, communities, and general public were developed in collaboration with the AAAs, Councils on Aging (COA) and Elder Affairs staff and administered centrally from Elder Affairs.

Data Collection Approach

A three-level data collection approach was used for the 2009 Statewide Needs Assessment Study. The primary level is information from need assessment events conducted by the AAAs. The secondary level consists of information from providers who render direct care services and from the Commonwealth's municipalities. The tertiary level is information garnered from the general public. The information gathered from these four sources address the Massachusetts' Executive Office of Health and Human Services (EOHHS) and Elder Affairs' initiatives as well as those identified by the Administration on Aging.

Some 6,225 elders and their stakeholders participated in 206 single -and multiple-day need assessment events conducted by the AAAs from October 2007 through December 2008. From among 279 providers who employ direct care workers, 36% (n=87) completed the questionnaire administered from August 15th through November 15th of 2008. Additionally, with 249 municipalities in the Commonwealth, 64% (n=224) of the communities completed a questionnaire administered from September 1st through November 15th of 2008. Finally, a questionnaire was posted on the 800AGEINFO website from August 15th through December 15th 2008 to learn about elder needs and concerns from the general public. Although some 550 respondents viewed the questionnaire, information is based on 521 participants.

Primary Level: Elders and their Support Networks

The AAAs conducted their own local needs assessment activities to prepare their local area plans. Since their findings would typically not be available until after the state plan is developed or submitted to AoA, AAA planners were asked to submit their findings to Elder Affairs after each needs assessment event using a single sheet reporting form. (The parameters for the decentralized data gathering activities and classification of needs under 16 areas of concerns are provided above.) In this manner, the findings from the AAAs need assessment events could be incorporated with the statewide findings.

Secondary Level: Communities and Providers

Elder Affairs sought to learn from direct care worker providers the needs and concerns they have in providing services to elders and their families through the Providers' Questionnaire. The information would assist us to ascertain what, if any, aspects of service delivery may need to be modified to ensure standards of care are uniformly delivered to elder consumers.

The focus of the Municipal Questionnaire was to gain a snapshot of the community's preparedness for both current and imminent aging of residents. The Municipal Questionnaire was composed of three parts, with Part A focused on what three services the municipalities currently provided, what five service areas they would focus on between now and 2013, and which from among 15 listed items they would recommend Elder Affairs focus on between now and 2013.

Part B is composed of four sections labeled Safety and Security. Items generated were developed around two AoA Strategic Action Plan 2007-2012 Program Goals (specifically goals 2 and 3) and seven HHS Strategic Plan Objectives as well as Executive Office of Health and Human Services goals (specifically, Wellness and Quality of Health Care, and Safe Communities), and Elder Affairs initiatives pertaining to physical activities and falls prevention.

With emphasis for elders to remain in the community and falls a leading cause of unintentional injuries to elders, Section 1 sought to ascertain what trends were occurring in call demands for emergency medical services (EMS) in the communities. Section 2 sought to identify if the community maintained a registry or record of people who required additional assistance should a natural or man-made disaster or threat occur. Section 3 sought to identify

what types of evidenced-based prevention programs, especially falls prevention programs, were offered for elders in the community. Finally, Section 4 requested information about the types of physical activity programs and classes offered to elders and the availability of fitness equipment to elders in communities.

Part C of the Municipal Questionnaire was designed to learn about the community's preparedness for the aging population in twenty areas. Items were generated from 'livable communities' and 'aging in place' literature. As the individual within each municipality most knowledgeable on the topic of elder issues and services, the directors of the Councils on Aging and Senior Centers were asked to complete the questionnaire.

Tertiary Level: General Public

Finally, in an effort to open the Study to a wider segment of the general public, Elder Affairs posted a web survey to ascertain the most prevalent concerns and issues facing elders. The intent of the web based survey was to engage the perspectives of citizens under age 60 who provide care to elders, but who may not necessarily have been the focus of past efforts.

Study Findings

While the ranking of priority issues may vary from the different venues of data gathering, primary issues of concern are health care, financial security, transportation, family/caregiving/support networks, housing/home ownership, and maintaining independence/dignity. Secondary issues are education/learning, food and nutrition, leisure and recreation activities, long-term care, mental health services, and safety/security. Tertiary issues are career/employment, legal services, spirituality, and volunteer opportunities/civic engagement.

The major recommended service supports for Elder Affairs to undertake over the next several years, based on the Needs Assessment Study, include:

- Improving access/increase public and para-transit transportation options.
- Expanding affordable elder housing capacity and support options.
- Increasing home and health care workforce.
- Promoting healthy aging through physical activities, fitness and recreation including injury/falls prevention programs.
- Establishing a single, coordinated system of information and access for all persons seeking long-term supports.
- Investing in outreach to targeted populations to raise their awareness of available services and supports.
- Expanding capacity of protective services (abuse, fraud, financial exploitation, neglect and self-neglect) for elders.

The 2009 Needs Assessment Study results are an important means by which Elder Affairs can join with the Massachusetts elder network to focus on developing and planning services for elders and their caregivers through 2013. The broader reach of the 2009 endeavor provides the elder network with the opportunity to address Elder Affairs' effort to modernize its long-term care system through building greater capacity in home and community-based services and settings. The Study also permits Elder Affairs to translate data into possibilities for serving elders through the development of client-centered services that address elder needs.

Elder Affairs will benefit from the Study over the next several years as we continue to interpret its findings and take action on our course toward promoting and building capacity in home and community-based services and settings for elders. The Report of the 2009 Needs Assessment Study, including a full analysis of the data collected, is found in its entirety within Appendix D of the State Plan on Aging, 2010-2013.

Opportunities for Long-Term Care Modernization

Administration on Aging Focus Areas

The Administration on Aging has highlighted five focus areas that each State Unit on Aging must address in the composition of the 2010 State Plans. An assessment of the Massachusetts Executive Office of Elder Affairs' goals, missions and plans confirms our commitment to developing programs and services that emphasize health-centered, home and community-based care in meeting the unique needs and preferences of elders and their caregivers. With a focus on Community First, Elder Affairs recognizes the importance of enabling elders and individuals with disabilities to live independently and, where appropriate, within the community. As an emphasis on long-term care modernization is crucial in addressing demographic shifts in the elderly population, Elder Affairs presents the following activities in support of its effort to build greater capacity in home and community-based services and settings. The five AoA focus areas include:

1. Title VI and Title III Coordination
2. Title VII Vulnerable Elder Rights Protection Activities
3. Disaster Preparedness
4. Faith Based Initiatives
5. Health Care System Coordination

Title VI and Title III Coordination

The Older Americans act indicates that the purpose of Title VI is "…to promote the delivery of supportive services, including nutrition services to American Indians, Alaskan natives, and Native Hawaiians that are comparable to services provided under title III." While historically, Elder Affairs has not been the recipient of Title VI funding, a 2008 Demonstration Grant application for SMP (Senior Medicare Patrol) Integration Project funding was positively reviewed by the Administration on Aging, and an award of $100,898.00 was awarded through June 30, 2010.

The SMP Integration Project aims to develop innovative approaches to reach and educate isolated elders in rural areas and in counties with high American Indian/Native American presence about the SMP Program message and how to prevent healthcare errors, fraud and abuses. Elder Affairs has subcontracted with Elder Services of the Merrimack Valley, Inc. as the lead organization to coordinate and implement the SMP Integration Project in Massachusetts.

The goal of the SMP Integration Project is to foster national and statewide program coverage to rural, insular and American Indian/Native American populations, foster national program visibility and consistency in the dissemination of the SMP Program message, and deliver target training and education to isolated and hard-to-reach populations throughout the state. The major objectives and tasks for achievement of the project include:

<u>Broadening SMP Program Outreach:</u>

- Conduct a media campaign to develop language appropriate PSA/Commercials for multi-ethnic media, radio and community access television programs, to outreach and rural, insular and American Indian/ Native American populations throughout the state about healthcare errors, fraud and abuse.
- Develop and disseminate PSAs to local and culturally appropriate media, e.g. community newsletters, church bulletins, magazines, community television, etc. to outreach and heighten awareness of SMP Program message.

Conducting Meetings, Presentations and Community Forums:

- Plan, coordinate, convene and facilitate regular presentations and community forums to reach and educate rural, insular and American Indian/Native American populations.
- Establish a diverse and culturally competent SMP Integration Project Advisory Committee to help guide the project.
- Participate in the MA SMP Program Monthly Meetings and/or conference calls.
- Attend MA SMP Program's Regional Multicultural Task Force Meetings to broaden outreach and increase dissemination of information to rural, insular and American Indian/Native American populations about the healthcare errors, fraud and abuse.

Producing Publications:

- Integrate SMP Program Message into the following ELD administered Programs: Protective Services, Money Management, Family Caregiver Support Services and Long Term Care Ombudsman Program, and train workers and volunteers at AAA, ASAPs and ADRCs.
- Write article regarding the SMP Program message for community newsletters every other month and develop a survey to assess the knowledge base of service providers about the SMP Program message, on preventing healthcare fraud.
- Design packet for dissemination by staff and volunteers of the following ELD administered programs: Protective Services, Money Management, Family Caregiver Support Services and Long Term Care Ombudsman Programs to ensure effective outreach and education of rural, insular and American Indian/Native American populations throughout the state.

Designing Website Tools:

Contribute to the MA SMP Program www.medicareoutreach.org website and inform Medicare and Medicaid beneficiaries of how to identify and resolve health care fraud and abuse. Include updated current information on health benefits eligibility, post translated materials, provide linkages to Protective Services, Money Management, Family Caregiver Support Services and Long Term Care Ombudsman Programs to reach and educate rural, insular and American Indian/Native American populations throughout the state.

Developing Trainings and Capacity Building:

- Plan, Develop and Implement trainings to the staff and volunteers of the following ELD administered programs: Protective Services, Money Management, Family Caregiver Support Services and Long Term Care Ombudsman Programs to effectively train staff and volunteers from AAA, ASAPs and ADRCs.
- Plan, Develop and Deliver a series of trainings on "Why Cultural Sensitivity is Essential to Combat Healthcare Errors, Fraud and Abuse", to be delivered to staff and volunteers associated with the SMP Integration Project efforts.

In addition to this statewide effort, the Massachusetts' Area Agencies on Aging concentrated development efforts on Title VI and Title III coordination by addressing this topic within the 2010-2013 Area Plans. Each of the AAAs was required to address American Indian/Native American populations in their respective Planning and Service Areas. The results of this exploration were mixed, as the Native American population in many of the PSAs in Massachusetts is limited. (Native American populations are concentrated in the southwest region, Cape Cod and Islands, Berkshires, Boston (Jamaica Plain) and the Merrimack Valley). However, as each of the AAAs accepts the challenge to reach out to 60+ populations of all kinds, the following approaches highlight some AAA efforts to foster outreach to Native American populations.

- Several AAAs have adopted outreach efforts to insure that Native American elders are able to access benefits and services in the community. These efforts include survey tools that identify unmet needs relating to particular cultural needs and preferences, as well as coordinating efforts with local agencies, including public health and other social services agencies, in order to identify service opportunities.
- AAA newspapers and publications, in addition to local media outlets, will be used to conduct media outreach campaigns to alert Native Americans to available services.
- AAAs are developing culturally sensitive training programs and outreach materials in an effort to help tribal elders feel comfortable in accepting services from non-tribal providers.
- Two AAAs indicate plans to provide outreach materials to Native Americans at tribal operated gatherings, including health and benefit fairs.

As the Massachusetts elder network makes a concerted effort to address the unique service needs of Native Americans through promoting available services and information, the work to foster partnerships between mainstream entities and community-based organizations that have the established trust of this population, indicates the commitment of the network to address this challenge. The effort to deliver essential aging services and educate underserved, un-served and hard-to-reach Native Americans elders will continue throughout the life of the State Plan 2010-2013.

Title VII Vulnerable Elder Rights Protection Activities

In addressing the AoA goal of ensuring the rights of older people and preventing their abuse, neglect and exploitation and in connection with Elder A ffairs' focus on preventing and responding to reports of elder abuse, the Massachusetts aging network directs an elder rights protection program that is focused and responsive. Elder Affairs' partnership with AAAs and the aging network continues to focus on a variety of approaches to accomplish the goal of ensuring the rights of elders. Services are always offered and provided based on the wishes of the elder and employ the philosophy of 'least restrictive, appropriate intervention'. Strategies focus on elder neglect and abuse prevention, advocating for elders' rights within long-term care facilities, continuing support of legal services for elders and the emerging role of legal assistance development at the state level. Title VII Federal funding supple ments State funding and allows for increased opportunities to develop new opportunities and strengthen the elder rights protection activities in Massachusetts.

Protective Services Program

In partnership with the AAA network and other state agencies, Elder Affairs has designed a framework for expanding capacity of protective services for elders. The effort is based on four tenets for providing; training, outreach, collaborations, and prevention. These efforts highlight the cornerstone of the Protective S ervices (PS) Program.

Training. One of the proven methods of providing competent protective services is to provide the best training possible for the caseworkers and supervisors who provide the direct service to vulnerable elders. Elder Affairs has cont inued to improve the level of training that is offered and required of program staff. The PS Program now manages contracts with the Institute of Geriatric Social Work program at Boston University (BU -IGSW), in offering an on-line five course curriculum th at provides each participant with a Certificate in Aging. Intensive training ensures that each direct service provider has the opportunity to improve their ability to work effectively with elders and the person who is reportedly abusing, neglecting or exploiting the elder.

Elder Affairs has identified and contracted with qualified professionals to provide training and consultation on sexual abuse and financial exploitation. Meetings are scheduled on a quarterly basis to discuss cases and share successes as well as problem cases. The contracted professional is also available to this group to discuss cases as they are being investigated. Additionally, the availability of professionals to assist in complicated financial exploitation cases continues to be a program need. Elder Affairs promotes pro -bono opportunities for legal and financial professionals while looking for ways to reimburse for these services where possible. Addressing this unmet need is an on -going goal of the PS program over the next several years.

Outreach. Public education is achieved at multiple levels. The majority of interaction with professionals who are mandated to report possible cases of abuse is conducted by the twenty - two Designated Protective Services Agencies that provide al l the direct services to elders. These agencies are the foundation of our program and work collaborating with local professionals in all related disciplines. Information is provided through formal training, brochures, conferences and individual case disc ussions. Joint efforts are encouraged

whenever the targeted audience is shared with another PS agency, e.g. District Attorney's office. Elder Affairs brochure describing the PS program is distributed in eleven languages.

Elder Affairs also conducts outreach at the regional and state level. We respond to requests for cable television programs, radio shows and interviews with print media. The Elder Affairs PS unit continues its efforts to facilitate local program staff with program planning opportunities and conducts conferences that reach out to large groups of professionals. Recent appearances include presenting at a conference for mandated reporters, titled, Self Neglect: Will I know it when I see it?, and conducting a workshop titled, Substance Abuse and Protective Services - Do the 2 Mix?, at an Aging with Dignity conference co-sponsored by DPH - Bureau of Substance Abuse, Mass Partnership for Older Adults, Massachusetts Council on Aging, Elder Affairs, Mass Home Care & AdCare Educational Institute.

Collaborations. Partnerships continue to be an effective way of providing education to the largest audience possible, examples of collaborations include:

- Banks – The Elder Affairs PS unit has been developing collaborative arrangements for many years and is continuing to look for new ways to build partnerships. More than ten years ago we developed a protocol and training package for working with banks. The Bank Reporting Project has become a model throughout the country and we have helped other states develop a similar program. We have recently renewed our training efforts, revised the training manual to be more user friendly and this year began expanding the project to work with credit unions.

- State Agencies – Elder Affairs has several projects with the State Department of Public Health (DPH). We have met with Rape Crisis Counselors from across the state to promote understanding and more interaction. Local PS agencies have continued this effort by providing training at the local level. In return, arrangements are in process to have staff of DPH attend the Sexual Abuse Consultants' group to share concerns and to learn from each other.

  Elder Affairs has also joined efforts with the Department of Public Safety to develop a curriculum for police officers.

- Medical Partnerships – Several affiliations have been forged to improve the knowledge base of medical professionals and to improve access for medical care by elders. Elder Affairs PS staff are now part of the curriculum at Regis College's Nurse Practitioner Program and at the Mass College of Pharmacy and Allied Services – a program for Physician's Assistants. Exploration of a formal arrangement between one of the medical insurance programs that covers most of the Commonwealth and the local PS programs is underway. We are piloting the concept with one PS agency that has a large elder population that utilizes that insurance program. Another large medical insurance program has expressed interest and we will be pursuing that over the next year or two.

- Multi-disciplinary Teams – A recent Department of Justice grant received by the Attorney General's office involved a joint training project between PS and law enforcement that developed Elder Abuse Roundtables. Massachusetts now has six areas of the state that have developed formal Roundtables and meet regularly to discuss issues affecting elder safety. The Roundtables continue to forge ahead in

their effort to sponsor conferences and legislative information events in addition to consulting on barriers to effective service for abused elders. The teams usually include some combination of professionals from local PS agencies, law enforcement, District Attorney's office, family service agencies, public health, housing, Domestic Violence Shelter/Counseling agencies and Rape Crisis Centers.

- Educational – Elder Affairs was recently asked to participate in the Advisory Board of a new Forensic Nursing Program at Boston College. A member of the PS unit now sits on that board and is helping to ensure that all p opulations are involved in the curriculum content. In addition, Elder Affairs will be developing an internship for a student of that program for FY2011.

Prevention. The Massachusetts Money Management Program is a direct service provided through a collaboration of Elder Affairs, AARP and Mass Home Care. Using a model developed by the AARP Foundation, Elder Affairs contracts with twenty-five ASAPs to provide volunteer based services to protect elder's who need assistance with managing their income. Paid coordinators, mostly half-time positions, recruit, train and oversee a group of volunteers who go to elder's homes at least monthly and help to budget income, pay bills and balance check books. In more serious cases, these volunteers are able to serve a s Representative Payees through the Social Security Administration. In those cases the volunteer is empowered to make financial decisions for the elder and make sure that their Social Security check is used for their well-being. Elders who might be prema turely institutionalized due to unpaid rent or other necessities are maintained at home with the dignity they deserve. Those who have been exploited by family or friends can regain control or have someone trustworthy appointed to act on their behalf.

Activities of the Protective Services Program are developed and implemented to support a focus on investigating reports of abuse, neglect or financial exploitation and offer appropriate services or interventions to those who are determined to be at risk of fu ture abuse. In support of this effort, Elder Affairs and the elder network are currently in the process of developing the Adult Protective Services solution (APS) as a flexible, web-based integrated case management system configured specifically for Prote ctive Service agencies and based on industry best practices. As a component within the Senior Information Management System (SIMS), the APS solution meets a range of needs often reported by APS agencies, such as workflows that help workers clearly follow the steps throughout the APS process from intake through investigation; management tools that help ensure proper supervision of APS staff; reporting and automated business processes that provide clear alignment between actions and policies and procedures.

Long Term Care Ombudsman Program

Title VII of the OAA authorizes the Long-Term Care Ombudsman Program (LTCOP) to work to improve the quality of life of residents in nursing homes and board and care homes (rest homes) by acting as their independent advoca te. Elder Affairs certifies 24 local programs that provided coverage in specific geographical areas. Ombudsman staff and volunteers informally investigate and resolve complaints on behalf of residents. They visit long-term care facilities on a weekly ba sis to be accessible to residents and their families. In addition Ombudsman are trained to observe environmental issues, facility compliance with laws and regulations, staff/ resident interactions, and staff responses to resident needs all of

which impact the quality of life for residents. Ombudsmen also provide education regarding long-term care issues, including abuse and neglect and resident rights to residents, families and staff, and identify long-term care concerns and advocate for needed change.

In FY2008, the Ombudsman Program received 9,217 complaints: 8,859 in Nursing Homes and 358 in Board and Care Homes (Rest Homes), resolving 92% of complaints to the satisfaction of residents. Ombudsman responded to the majority of complaints received within one working day.

The core of the Program continues to be volunteers, with 355 trained and certified volunteers in FY2008 providing regular weekly coverage of long term care facilities, providing access to residents and their families. State Office staff promotes timely and consistent certification training using State developed and approved volunteer training curricula and administers certification examinations. Elder Affairs will continue the effort to develop training and curricula for bi-annual volunteer re-certification as well as materials for use in local program monthly trainings.

As a key focus of the LTCOP, advocacy and education initiatives include:

- Advocating for Increased Personal Funds for Nursing Home Residents. Ombudsmen participated in a statewide effort to advocate for an increase in the Personal Needs Allowance from $60 monthly to $72.80. Working together with nursing home residents, families, facility staff, the Coalition to Reform Eldercare (CORE) and others, advocacy efforts were successful in obtaining the increase for residents.
- Promoting Quality Improvement in Nursing Homes. Ombudsmen, together with providers, regulators, other consumer advocates, and the MassPro (QIO) , work to promote quality in Massachusetts' nursing homes. Goals include reducing pressure ulcers, improving pain management, and reducing the use of physical restraints.
- Supporting Culture Change. As key members of the Massachusetts Culture Change Coalition, Ombudsmen are involved in promoting "culture change" in nursing homes, focusing on resident directed care practices. LTCOP members are also participating in the Massachusetts Falls Coalition and the Interdisciplinary Pressure Sore Coalition, in an effort to have a direct impact on the quality of life of residents in long term care facilities.
- Developing Education Initiatives. In collaborations with the Department of Public Health, the Office of Attorney General, and Elder Affairs, the provider community has developed a series of trainings on abuse and neglect issues including recognizing abuse, investigation techniques, sexual abuse investigations, reporting requirements and prevention protocols. These training sessions are designed for administrators, director of nurses, social workers and other key administrative staff and are offered throughout the state on an annual basis.

Legal Assistance Development Program

Pursuant to sections 307(a)(13) and 731 of the Older Americans Act, Elder Affairs has recently re-committed to providing leadership in developing legal assistance programs by

identifying personnel to serve as the Legal Assistance Developer (LAD). The LAD, in keeping with Federal direction, will provide State leadership to secure and maintain the legal rights of older individuals by:

- Performing a thorough analysis of the 2009 Needs Assessment Study.
- Conducting an electronic survey of the most acute legal needs of elders as identified by the AAAs.
- Supporting and actively working with the Women's Bar Foundation of Massachusetts as it revamps and expands its Elder Law Project (ELP). The ELP offers pro bono estate planning documents for low income elders. This includes the provision of simple wills, durable powers of attorney, living wills, health care proxies and Homestead Declarations.
- Advising SUA leadership of existing, proposed or needed legislation to protect or enhance the rights of elders.

The LAD support of coordination and collaboration between vital components of the legal service delivery system will include the following focused strategies:

- Actively participating in the application for the AoA grant for Model Approaches to Statewide Legal Assistance Systems which would enable Massachusetts to build an efficient and comprehensive intake, advice and referral system for elders.
- Beginning outreach and information gathering with Massachusetts law school clinics.
- Participating in regular information gathering meetings with existing Legal Services Providers.
- Collaborating, on an ongoing basis, with both the Elder Affairs Ombudsman Programs and the Protective Services Program.

Elder Affairs efforts to include LAD plans for FY2010 and beyond include:

- Developing reporting systems that measure legal assistance program impact.
- Refining existing legal service delivery standards that e nsure statewide quality, cost effectiveness, and consistency of service.
- Promoting State capacity to provide technical assistance, training and other supportive functions to AAAs, legal assistance providers, ombudsmen and others.
- Promoting State capacity to promote financial management services to older individuals at risk of conservatorship.
- Hosting a quarterly Advisory Committee of legal service providers from all involved and potential providers of low cost or free legal services for elders.
- Promoting State capacity to assist older individuals in understanding their rights, exercising choices, benefiting from services and opportunities authorized by law, and maintaining the rights of older individuals at risk of guardianship.

Disaster Preparedness

Historically, Elder Affairs and the aging network have planned for the potentially adverse impact extreme weather conditions and other disasters might have on the Commonwealth's elders who are long-term care clients receiving services from the state's home care, protective services, information services, or nutrition services programs. Additionally, AAAs continue their commitments to elder clients care needs that would require special attention during emergency or disaster situations, such as transportatio n services for critical medical treatments. The threat of a possible flu pandemic also requires planning for serious reductions in staff among ASAP/AAAs, collateral agencies and service providers.

The following are methods the elder network in Massachu setts has adopted and is developing over the next four years to establish emergency preparedness and disaster assistance strategies on behalf of at-risk, vulnerable elders throughout the state.

Continuity of Operations Plans

In 2009, Elder Affairs will re-convene an interagency workgroup to update emergency management plans for elder services in the Commonwealth. Elder Affairs and the elder network design of the Continuity of Operations Plan for Reductions in Work Force Caused by Pandemics and Disasters would be implemented during severe staff reductions such as those caused by disasters or disease pandemics. Annual review of Continuity of Operations Plans (COOP) is necessary to address new emergent safety threats , technological advances in communications, and data management.

MA State Task Force on Emergency Preparedness and People Requiring Additional Assistance

The tragic legacy of Hurricane Katrina underscored the disproportionate impact of disasters on elders, people with disabilities and people of lower socio-economic status. As a result, during 2007-2008, nearly 60 community organizations and over a dozen Massachusetts state agencies, including the Executive Office of Elder Affairs, the Massachusetts Emergency Management Agency, the Mass Office on Disability, the Department of Developmental Disabilities and the Office on Disabilities and Community Services, came together to discuss the state of emergency preparedness in Massachusetts as it relates to individuals requiring additional assistance during times of emergency. In less than one year the alliance of concerned organizations evaluated the ability of people to access emergency management services, discussed the implications of the evaluation and generated recommendations that will help keep all people safe in times of emergency.

The Task Force concluded that the Commonwealth's emergency infrastructure requires improvements to remove or mitigate barriers that prevent all individuals from accessing emergency products and services. The Task F orce recommended that the Commonwealth strive to ensure that:

- All state and local government emergency shelters comply with the Americans with Disabilities Act (ADA);

- Individuals requiring additional assistance during an emergency should have equal access to shelter and evacuation services, facilities, products and training and should be included as stakeholders in the design, development, delivery and evaluation of such services.
- The Commonwealth play an active role in ensuring individuals receiving supports from state funded programs, along with service organizations that serve them, develop preparedness plans
- The Commonwealth encourages the enhancement of emergency training programs so that training is universally accessible and that first responders receive specialized training to enable the delivery of their services to all individuals without injury. Further, the Taskforce recommends the Commonwealth encourage local government agencies to view individuals requiring additional assistance during emergencies as subject matter experts and include those individuals in the design, development, delivery and evaluation of emergency services, facilities, products and training.
- Assistance is provided in the effort to ensure that all individuals are prepared for their own safety and to provide varied methods of support to enable planning for all individuals.

Training 349 Municipal Senior Center and Council on Aging (COA) Staff on Emergency Preparedness and First Responder Roles

In November, 2006, members of the Massachusetts Association of Councils on Aging and Senior Center Directors' Emergency Planning Task Force, including the Executive Office of Elder Affairs, met to explore what roles COAs currently perform or might assume at the local level to improve how elders fare during emergencies and to develop materials to support COA personnel in performing those roles. The group anticipated the potential roles a COA may perform during emergencies and delineated the issues staff must consider as they undertake various roles. The COA Emergency Planning Task Force decided to develop an educational manual about emergency management that will help the community-based elder services staff understand emergency management issues and protocols, and to produce outreach materials that can support the staff's efforts to build a culture of personal preparedness.

In 2007, the *Emergency Preparedness Resource Manual* was developed that provides an overview of the local emergency management planning process, basic operations guidelines for specific emergency response roles that COAs may perform, a newsletter article series to integrate personal preparedness information into outreach efforts, and information on how individuals can achieve personal preparedness. The manual is available for other community based elder service organizations to use via the MCOA web site (http://www.mcoaonline.com/) under "Lending Library".

Community Outreach and Education Activities about Personal Preparedness

Concerning the larger community of residents in the Commonwealth, Elder Affairs has partnered with the MA Department of Public Health (DPH), resulting in a 2008 CDC grant award for $50,000 for the purpose of providing personal preparedness training materials

(150,000 copies of the American Red Crosses Disaster Preparedness – For Seniors by Seniors*)* to individuals via Council on Aging programs and events . Additionally, the grant funding will be used to produce emergency preparedness training programs and distribute them across the state's cable TV network. The telecast is going into production in the summer of 2009.

In addition, Elder Affairs has arranged for DPH and Red Cross staff to provide emergency preparedness training to COA staff at state conferences for community based elder service organizations on how to prepare themselves and their families first, so they can also be available to help other residents during emergencies. This followed upon previous trainings in Emergency Management that were provided in connection with the production of an Emergency Management Resources Manual for COA personnel that is posted on the MCOA online website.

Faith Based Initiatives and Partnerships

In response to the AoA request to include in the 2010-2013 State Plan a description of activities Massachusetts will undertake to involve faith-based and community organizations in the coordination and delivery of services to elder and caregivers, Elder Affairs approached the AAA network for assistance. As there is currently no formal arrangement between Elder Affairs and faith-based organizations, the AAAs are the link in ensuring the continued development of strong affiliations with local faith-based organizations contractually and with networking relationships.

In helping Elder Affairs to meet its goal of expanding and strengthening collaborations and partnerships across public and private sectors, and meeting the AoA goal to easily access existing health and long-term care options, the AAAs in the Commonwealth have designed a number of beneficial approaches to support faith based organizations in service to elders.

- In building on a Robert Wood Johnson Faith-in-Action grant several years ago, several AAAs have continued the aim of the program to build and renew relationships with local faith based organizations with a focus on volunteer recruitment and training. The continued effort highlights the value that faith based organizations and volunteers can add to the mission of alleviating isolation and helping to build communication networks that improve access to services.
- In efforts to integrate I&R service possibilities and general outreach to community elders, several AAAs have initiated databases of faith based organizations in their PSAs.
- AAAs have committed to promote outreach possibilities with faith based entities by several methods including, advertising in church bulletins, providing education sessions to clergy and parishioners on elder subjects and services, encourage faith based groups to apply for Title III grants, and pledging membership on interfaith committees.
- The work to collaborate with faith based groups continues to develop as AAAs plan opportunities over the next four years to serve meals from churches and faith based

community centers, coordinate with Parish Nurse Programs on available service opportunities, and collaborate with faith based institutions in developing strategies and possibilities for future endeavors.

There are abundant examples of AAAs working with faith based organizations across the Commonwealth to advance elder services in communities. Strong relationships have been built over years and the network, including faith based groups, are committed to preserving past efforts in building for future success to increase information sharing, resources, and service expansion. Faith based groups offer a unique perspective on community connections and are well positioned to continue assisting the AAA network in meeting the goal of building greater capacity for elder services. Elder Affairs joins the AAAs and faith based organizations in Massachusetts as we combine resources and continue to explore strategies to build effective community-based programs and services for elders and caregivers.

Finally, Elder Affairs engages representatives from Greater Boston Interfaith Organization (GBIO) to input on needs and ways to make www.800ageinfo.com website a more powerful and useful tool for elder consumers and their families. Since the goal of the project is to revamp the www.800AgeInfo.com website so that it provides easy access to accurate and relevant information needed by individuals who make up a similar profile to members of the GBIO, it was important to get their input at regularly scheduled focus group meetings. GBIO helped Elder Affairs to better understand consumers who attend diverse faith-based organizations and what they might need from the website so that our agency builds a site that works well.

Health Care System Coordination

Elder Affairs and the Massachusetts Department of Public Health (DPH) are involved in a wide variety of healthy aging activities that involve collaborative efforts. There is a long history of collaboration on health promotion and disease prevention activities between Elder Affairs and DPH that has involved joint program planning, participation on advisory groups and boards, conference planning and participation and development of educational materials. These relationships have grown steadily over the years and have involved numerous staff from both agencies. Along with other focus areas located in the State Plan 2010-2013, selected collaborative activities related to health care system coordination and healthy aging include:

Elder Affairs/DPH Interagency Agreement

The most important and potentially far reaching collaboration between DPH and Elder Affairs is an interagency agreement between the two agencies, signed by the Secretary of the Executive Office of Elder Affairs and the Commissioner of Public Health. This Interagency Agreement, originally signed in October, 2002, formalizes and institutionalizes relationships between the two agencies and makes collaborative efforts explicit. This agreement is updated on a regular basis to incorporate new collaborative initiatives.

A recent collaboration between Elder Affairs and DPH addresses End of Life Initiatives as both agencies serve as part of the Core Team directing implementation of end of life

initiatives mandated by the Massachusetts legislature, Chapter 305 of the Acts of 2008, Sections 41, 42 and 43, including:

- Developing a pilot program to test the implementation of the physician order for life-sustaining treatment (POLST) - to assist individuals in communicating end of life care directives across care settings.
- Convening an expert panel on end of life care for patients with serious chronic illnesses that is being tasked with identifying best practices for end of life care, including those that minimize disparities in care delivery and variations in practice or spending among geographic regions.
- Initiating a public awareness campaign to highlight the importance of end of life care planning.

Evidence-based Programs

Elder Affairs, in partnership with the DPH Office of Healthy Aging and Disability, lead the US Administration on Aging Empowering Older People to Take More Control of Their Health Through Evidence-Based Disease Prevention Grant in Massachusetts. The purpose of the grant is to expand the capacity to deliver the following three evidence based programs:

- Healthy Eating for Successful Living (HE). Healthy Eating is for older adults who want to learn more about nutrition and physical activity for improved health. This six-week program focuses on nutrition strategies for heart and bone health to help maintain or improve participants' wellness and independence and to prevent the development or progression of chronic disease. The HE program has expanded by 65% to a total of 38 host sites located in south suburban Massachusetts, Boston, Metro-west, and Southeastern Massachusetts. One hundred-fifty people attended a total of nineteen workshops, surpassing the total of one hundred attendants for all of the first year. Twenty-two master trainers and twenty lay leaders were trained. The program is in the final stages of translation into Russian to reach the large Russian speaking population in Massachusetts.
- My Life, My Health, Chronic Disease Self-Management (CDSMP). My Life, My Health is a series of 2 ½ hour workshops that take place once a week for six consecutive weeks. These sessions are for people with chronic health problems and those who care for people with chronic conditions. Participants find ways to deal with pain and fatigue, discover better nutrition and exercise choices, understand new treatment choices and learn better ways to talk with their doctor and family about their health. Eighty-two communities now have access to CDSMP, an increase of 95 percent over last year. This year, 839 participants have attended the 58 workshops conducted with an average attendance of 15 participants per workshop. Workshops were held in Spanish for 72 participants and in Chinese for 24 participants.
- A Matter of Balance (MOB). Many older adults experience concerns about falling and restrict their activities. A Matter of Balance, an eight-week program, is designed to reduce the fear of falling and increase activity levels among older adults. The number of participants completing the program in Year 2 is 254 compared to 71 for

all of last year. The number of trained coaches has grown to 69, covering Boston, the Northeast, and Central Massachusetts.

This grant partnership is now focused on expanding the number of settings for program implementation, with the goal of eventually offering all three programs statewide. We are specifically targeting Councils on Aging and senior centers; Area Agencies on Aging; elderly nutrition programs; family caregiver support programs; community health centers; Title V Senior Community Service Employment Programs (SCSEP); independent living centers; health care insurers; Medicaid and public health programs. Our goal is to reach 80% of the state's communities with these evidence based-programs by 2013.

Our goal is to develop systems to deliver high-quality evidence-based programs that provide the maximum number of at risk older adults and people with disabilities with tools to maintain healthy and active lifestyles. In addition, Massachusetts plans to develop policy and system changes to support an infrastructure to implement evidence-based programs statewide.

The expected outcomes of the evidence-based program initiatives are the following:

- Existing public/private partnerships expand their capacity to integrate evidence-based programming into local and statewide systems.
- Older adults and people with disabilities report improvements in: falls management, better strategies for coping with disease, more nutritious food choices, and increased levels of physical activity.
- Expected project products for facilitating future opportunities include: semi annual reports, program implementation protocols, evaluation and data monitoring tools, marketing materials, and a statewide strategic plan for implementing and sustaining evidence-based programs.

The Executive Office of Elder Affairs is particularly interested in enhancing coordination of programs and services between state agencies that address needs of elders and people with disabilities, e.g. Massachusetts Commission for the Blind, Massachusetts Commission for the Deaf and Hard of Hearing, Massachusetts Rehabilitation Commission, Massachusetts Department of Developmental Services (formerly DMR), and Massachusetts Department of Mental Health.

One example of such an initiative is a collaborative effort around low vision between Elder Affairs and the Massachusetts Commission for the Blind, the Perkins School for the Blind and the Carroll Center for the Blind. Sixty percent of people with low vision are age 60 and older. The social and financial implications of this problem are enormous, affecting mobility, independence, mental health and quality of life overall for elders. Elder Affairs efforts over the next four years are to address low vision initially through training providers within our aging services network.

An initial kick-off event was sponsored by Elder Affairs and included presentations addressing the magnitude of the low vision problems, the importance of screening for low vision problems, common eye disorders, adaptive devices, both low and high tech, that can

make a big difference in the life of a person with low vision, agencies that address low vision problems and resources that providers and clients and their families could access easily. Subsequent activities will include more in-depth training to staff at the AAA/ASAPs and the Councils on Aging and senior centers, including a video program on low vision on "Senior Scene", the Elder Affairs sponsored cable program available to be downloaded statewide. Additionally, workshops on low vision have been accepted for presentation at the Massachusetts Councils on Aging 2009 annual conference.

The leaders in the field have a deep and comprehensive understanding of the needs of the elderly blind and visually impaired citizens of the Commonwealth, including social services, health services and adaptive equipment that would foster the achievement of full and independent living. The main issue is getting information out to providers and clients regarding resources and helping people to access the programs and services that are available. Elder Affairs will work to facilitate strategies that let people know that there is help out there for clients with low vision.

Executive Office of Elder Affairs Focus Areas

The following topics highlight the service and advocacy work that the elder network in Massachusetts is performing to promote the independence and well-being of individuals, their families, and caregivers through the development and delivery of quality services. It is these efforts, along with an ongoing commitment to cultivating possibilities for new program design and development, and promoting long-term care modernization, that indicates Elder Affairs' drive to provide quality, consumer directed services to elders. The focus areas spotlight Elder Affairs' goals as listed earlier in the State Plan, and as examined collectively, highlight Elder Affairs' collaborations and partnerships in addressing populations and services as guided by the Older Americans Act and the Administration on Aging.

Goal Number One. Build Greater Capacity in Home and Community-Based Services and Settings. In illuminating the first four focus areas, Targeted Populations, Rural Elder Populations, Access to Services for Adults with Limited English Proficiency, and Measuring Performance, Elder Affairs' goal of building greater capacity in home and community-based services and settings comes to the forefront. Focusing on OAA mandated populations, advocating for and developing services for elders, and improving service quality are key to capacity building.

Goal Number Four. Expand and Strengthen Collaboration and Partnerships Across Public and Private Sectors. While cooperative partnerships are included throughout the State Plan, Goal Number Four is highlighted here in support of the Elder Affairs focus areas. Elder Affairs recognizes the value that collaborations and partnerships add to building and maintaining community-based services. These efforts include building and strengthening partnerships with State agencies to align mutual goals; collaborating more closely with colleges and universities to develop and evaluate services; and, working with consumers and caregivers, as well as providers and direct service workers, to monitor service quality and effectiveness.

Targeted Populations

The Older Americans Act target populations continue to form the foundation for elder services planning, development and delivery in Massachusetts. The U.S. Administration on Aging Strategic Action Plan for 2007-2012 identifies a vision for long-term care modernization that helps older adults to learn about and access opportunities for maintaining their health and well-being in the community. In adopting this vision, Elder Affairs and the Area Agencies on Aging continue to advocate for and commit resources to those most vulnerable populations of elders residing in the Commonwealth. The elder network makes great effort to locate elders in greatest economic need, physically and socially isolated elders, while placing a particular importance on addressing the needs of low-income elders. The network has also targeted individuals with limited English proficiency with an increased awareness as an Older Americans Act targeted population.

The following figures represent the Massachusetts 60+ elder population for each of the highlighted populations as extracted from the U.S. Census Bureau Population Estimates:

Native Americans/Alaskan Native	2,311
Native Hawaiian/Pacific Islander	533
Asian	30,303
Black/African American	46,870
Hispanic/Latino	36,786

Additional targeted population demographic data of the Massachusetts 65+ elder population is obtained from the U.S. Census Bureau American Community Study 3-Year Estimates:

Low-income Minority Elders (65+)	20,629
Elders with Limited English Proficiency (65+) (Those 65+ who do not speak English well or not at all.)	55,573

Rural Elder Populations

As required by the Older Americans Act and in support of Elder Affairs' mission to provide access to services for all elders 60+ and over, the elder network in Massachusetts focus on rural elders helps to identify and provide services to isolated elders. Seven of the twenty-three Area Agencies on Aging contain populations of elders defined as rural, that is, those areas containing less than one hundred persons per square mile. The Massachusetts aging network holds a tradition of highlighting services for rural elders and current efforts will strengthen resources for isolated elders.

In support of Elder Affairs efforts to focus needed resources and services on rural elders, the Massachusetts Intrastate Funding Formula assigns 5% of Title III funding to elders living in

rural communities. Additionally, the seven Area Agencies on Aging possessing rural populations have consistently maintained great efforts to reach out to and engage rural elders. The network works to engage isolated elders through outreach efforts and program planning that supports socialization and wellness activities, benefits counseling, including SHINE counseling, volunteer recruitment, and transportation services.

Elder Affairs will continue to foster and encourage communication, coordination and partnerships that enable Area Agencies on Aging with rural elder populations to identify and provide services to isolated elders. Each of the seven Area Agencies on Aging with rural elders have illuminated within their Area Plans 2010-2013, approaches for addressing the unique needs of this population. The following approaches highlight elder network efforts to serve rural elders over the next four years.

- Providing help and referral with applications for basic benefits such as Food Stamps, pantry and meal resources, fuel assistance and transportation services.
- Two Area Agencies on Aging with high proportions of rural elders each publish a monthly newspaper that reaches an estimated 6,400 rural elders in the two Planning and Services Areas.
- An Area Agency on Aging is promoting civic engagement in rural areas as a tool to cultivate local networks and partnerships that will bring financial resources to rural elders.
- The elder network in Massachusetts recognizes the importance of supporting family caregivers in their efforts to maintain elders in their homes. This effort is particularly significant in rural areas, as elders can often be isolated from support networks as well as family supports. Several of the Area Agencies on Aging with rural populations provide for special caregiver training opportunities, caregiver respite awards, and information sharing conferences and opportunities.
- Area Agencies on Aging will continue to use their Advisory Councils to focus on meeting the challenging needs of rural elders. One Advisory Council is being utilized in the next several years to develop best practices in meeting transportation needs and will help the AAA to direct a rural summit to identify special needs of elders who reside in rural towns in the Planning and Service Area (PSA). Additionally, AAAs continue to ensure that towns with rural elder populations are represented on Advisory Councils in order to communicate the unique needs of this population.
- Elder Affairs' focus on examining ways to create wage and benefit parity across long-term care settings for workers addresses rural elder issues as this effort can positively affect the availability of services in rural settings, as well as help to remove social and physical isolation, especially in the winter, of elder well-being for several of the AAAs.
- Elder Affairs is in the process of updating the www.800ageinfo.com website in an effort to ensure that the system is more easily accessible and used by all consumers. The goal of this project is to revamp the existing 800ageinfo website to ensure that it is user friendly, ADA compliant and to construct a usable web site that will provide efficient access to accurate and relevant information needed by elders, caregivers and

service providers. The timeline dictates that the project will be completed by th e summer of 2009.

Access to Services for Adults with Limited English Proficiency

Beginning in the Fall on 2008, Elder Affairs began a project to build into all of our programs and services the ability to welcome, respond to and serve elders with dive rse linguistic backgrounds who do not speak English at all or who do not speak English well, (commonly referred to as "limited English proficient" (LEP)).

A new partnership with the Massachusetts Office for Refugees and Immigrants (ORI) has been established to collaboratively develop a sustainable strategy for providing meaningful access to LEP adults to the information and services we provide. A formalized partnership included the development of a Memorandum of Agreement with ORI. The Memorandum was signed in February 2009 and states in part:

> "The Office for Refugees and Immigrants (ORI) and the Executive Office of Elder Affairs (EOEA) will collaborate to develop a sustainable strategy for providing meaningful access to LEP adults to the information an d services provided by EOEA. This may be accomplished by using a range of interpreting options, such as providing timely interpreter services via a third party, contracting with community -based organizations that have established the capacity to provide ac cess assistance for LEP adults, or employing bilingual staff to perform core direct service activities so that LEP refugee and immigrant elder participants will be able to communicate directly and effectively with key staff, without a 3rd party interpreter."

Strategies in achieving success in this project include:

1. Surveying current language access strategies of ASAPs and AAAs;
2. Identifying the level of need for interpreters and bilingual staff by the presence of spoken languages in Massachusetts communities;
3. Identifying where partnerships have already begun between ASAPs, AAAs and Community Based Organization and build new partnerships where needed;
4. Developing an Interpreter Brokerage Service with ORI to expedite the hiring of ad hoc interpreters for languages encountered infrequently;
5. Developing a statewide outreach plan with accompanying materials; and
6. Translating vital documents of programs.

At the end of 2009, once our language assistance services are in place, Elder Affairs will prepare a report on the project and the results of our work for the Administration on Aging to share with other State Units on Aging.

Additional elder network strategies that address LEP services include the SHINE (Serving Health Information Needs of the Elderly) pr ogram partnering with the Massachusetts SMP to

provide culturally and linguistically appropriate counseling services via telephonic and/or face-to-face statewide services. SHINE provides training to bi-lingual staff from community based organizations to provide health insurance counseling to limited English beneficiaries. Through this partnership with the SMP Program there are 40 SHINE certified bi-lingual counselors throughout the Commonwealth. Community based organizations that provide counseling services include: the Ludlow Area Adult Learning Center, Greater Boston Chinese Golden Age Center, Haitian American Public Health Initiative, Immigrants Assistance Center, Seton Asian Center, and the Russian Community Association. The languages served through this initiative include: Armenian, Chinese, Korean, Polish, Portuguese, Russian, Spanish, and Turkish. In addition to providing bi-lingual counseling, these individuals provide translation of SHINE materials increasing access to LEP elders.

Measuring Performance

In a commitment to measure the success of elder programs, Elder Affairs continues efforts to develop and implement performance measures and outcomes for elder programs. Collaboration between the Quality Manager and program managers includes developing program specific outcome language and meaningful measures. Additionally, the Quality Manager trains and consults with vendor staff to increase the understanding of Elder Affairs outcome development and reporting expectations.

The 1915c Frail Elder Waiver is an example of a program where performance measures based on CMS Quality Assurances were identified, implemented and measured. Quality Reviews occurred at all 27 ASAP sites to ensure the sites are compliant with Elder Affairs quality standards and expectations. The recent completion of ASAP Quality Site Reviews ensured that ASAP staff are meeting all requirements in regards to providing home and community-based services to the Frail Elder Waiver population. A thorough record review of 781 Frail Elder ASAP records identified areas needing corrective action as well as identified "best practices" which will be recommended across the ASAP network. The process also included direct interviews with many levels of staff at each ASAP site to ensure that policies and procedures are in place and are being implemented as necessary

Recent accomplishments and future plans for developing and implementing performance measures include:

- Developing Core Consumer Outcomes for the 1115 Community First Demonstration in conjunction with Massachusetts Rehabilitation Commission and the Office of Medicaid.
- The AoA Grant for POMP (Performance Outcomes Measures Project) Next Generation was awarded to Elder Affairs to continue the development of performance outcome measurement tools for Title III programs. The new tools being considered will address predictive modeling and longitudinal studies which will reflect consumer outcomes over a longer period of time.
- Piloting AoAs Consumer Outcome Survey Tools as part of the initial POMP grant for Title III programs. Specifically, Congregate Meals, Family Caregiver Support and Information and Referral were the programs involved. The findings from the pilot

process redefined and validated the final survey tool approved by Ao A for use across the country by all Title III programs. Massachusetts' congregate meal and home delivered meal programs are using the approved tools. The Massachusetts Family Caregiver Support Program will be also implementing a new survey tool based on the approved AoA tool.

- Instituting new quality assurance measures for Elder Affairs home care programs. Implementation will occur in 2009-2010, and new components will be added, including ensuring that elder consumers of home care services and their fami lies have a voice in program design and development.
- Helping to develop a set of consumer outcomes and quality reporting strategies, as a representative on the System Transformation Grant – Quality Subcommittee, that will apply across many EOHHS agenci es, including Elder Affairs
- Supporting a new project, as part of the System Transformation Grant - Quality Subcommittee, called "Photovoice". Beginning in May 2009 "Photovoice" gives consumers of long-term support services the opportunity to document the impact of services on their daily lives via photographs and written comments, giving their perspectives on quality (quality of life and quality of services). The exhibit will be shared with stakeholders across the state
- Intradepartmental reporting to EO HHS, named Active EHS Results, continues to reflect progress made by Elder Affairs programs towards meeting policy -level goals as well as analyzing outcome metrics against policy goals to find opportunities for improvement. This reporting assists EOHHS an d Elder Affairs leadership with evaluating, promoting and delivering policy priorities.
- Input from ASAP staff to identify areas Elder Affairs will need to address the Senior Information Management System (SIMS) team in regards to managing data in the electronic record.
- Training and consulting on outcome developments provided to SHINE Program vendors and the Massachusetts Family Caregiver Support Program vendors. These training opportunities gave vendors an understanding of why measuring outcomes is important to their programs and how it relates to overall quality improvement activities within EOHHS and Elder Affairs.
- Future consultation discussions regarding guided outcome development and performance goals with programs including, Senior Community Servi ce Employment Program (SCSEP), Supportive Housing, Nutrition and Geriatric Mental Health.

Goal Number Two. Improve Access to Services. The commitment to improve access to services has long been a priority of Elder Affairs. Providing comprehensive infor mation about issues, service options and programs is crucial to allowing elders to remain in their homes and community-based settings for as long as possible. A focus on Transportation Needs and Service Opportunities, Aging and Disability Resource Centers , Housing and Home Ownership, Long Term Care Options Counseling Program, a nd Mental Health Collaborations indicate the commitment our network, including private partners, has made to raise the awareness of services and supports for elder and caregivers.

Transportation Needs and Service Opportunities

Elder Affairs continues to identify transportation for elders as a significant service demand across the Commonwealth. Recognizing the need for transportation services is evident from analyzing the 2009 Needs Assessment Study, listening to elders at AAA focus groups, and working with Councils on Aging to develop and deliver cost-effective transportation services. Access to health care, community events, shopping, and other service opportunities is central to elders remaining in their communities. As the loss of independence and mobility are distinctly tied to surrendering car and license, it is necessary to cultivate and offer alternatives toward assisting elders where they live and help them to remain as active members of their communities.

The challenge in Massachusetts, as is the case in many other states, is making transportation services accessible and available, while providing affordable choices that promote and encourage elders to remain in their homes and community-based settings. The loss of independence and mobility often begins with the loss of driving. The ASAPs, AAAs and Councils on Aging have partnered with local transportation providers across the Commonwealth in significant measure to address this need. The following examples indicate ongoing collaborations to engage providers, elder service agencies and local governments in the provision of transportation services for elders.

- AAAs have long established and promoted volunteer medical transportation programs that serve elders requiring assistance and support to medical appointments. Volunteer drivers are trained on providing safe transportation services and client assistance.
- As Regional Transit Authorities (RTA) frequently have fixed route service, AAAs use Title III funding to enhance transportation services for elders by contracting with local governments and private providers. Arrangements of this nature highlight the networks' effort to strengthen resources and possibilities for assisting elders to remain in their communities.
- The network encourages elders to use all available public, private and volunteer transportation services. Connections, partnerships and information sharing between local governments, Councils on Aging, RTAs, and AAAs continue to develop and be reinforced toward the goal of meeting the overwhelming demand for transportation. Collaboration efforts are the main focus of these partnerships as AAAs identify elder transportation services as a vital need, revealed by the 2009 Needs Assessment Study.
- A local AAA has applied for and received a United We Ride grant to explore creating collaborative efforts in Massachusetts' North Shore around elder medical and social transportation. Should the pilot prove successful, Elder Affairs anticipates using the model as a template at other AAAs throughout the state.
- Several AAAs participate in the Mobility Assistance Program (MAP) of the Executive Office of Transportation. MAP provides for capital assistance to public agencies for the purchase of vehicles and related equipment to be used in the provision of transportation services to the elderly, persons with disabilities, and families transitioning from public assistance to employment for which existing public and/or private mass transportation is unavailable, insufficient, or inappropriate.

- The Massachusetts Bay Transportation Authority (MBTA) provides discount rides to elders through the RIDE para-transit program. Lift equipped vans are used to serve persons with disabilities, including those who use wheelchairs and scooters. The RIDE provides door-to-door transportation to eligible elders who cannot use public transportation because of physical, cognitive or mental disability. The RIDE operates services in 62 cities and towns neighboring Boston; a map of the RIDE communities can be found at www.mbta.com/riding_the_t/accessible_services/default.asp?id=7108 .

In addition to the above efforts, Elder Affairs is an active member of the Advisory Board for the Human Services Transportation (HST) Office of the Executive Office of Health and Human Services. The HST Office is working on state wide strategic planning concerning regional transit authorities as well as a more targeted effort on an adult day health transportation project around pricing, collaboration and performance standards . Additionally, the 2009 formation of the Elder Affairs Transportation Advisory Board (TAB) meets quarterly to review best practices and review funding opportunities for enhancing access for seniors within present transportation programs . The TAB group is also charged with defining service gaps, and proposing possible solutions to, services for urban and rural elders. Participants include AAAs, COAs, the Executive Office of Transportation, Adult Day Health transportation providers, consumer board members from the MBTA RIDE program and other non profit and for profit firms involved in aging and disability transportation programs.

The demand to address transportation services for elders across the Commonwealth has been apparent through past State Plans on Aging, and the 2010 edition supports th e same contention. While efforts are made to address service nee ds, as noted in the above illustrations, there still exist significant gaps toward providing necessary transportation services to elders. Obstacles include financial limitations, dysfunctional land use patterns, provider boundary conflicts, and inadequate coordination of current services. Elder Affairs intends to explore new opportunities for expanded and efficient transportation services over the next four years.

While Elder Affairs' role in transportation services is relatively minor in the state, we intend to continue our efforts, in partnership with the AAAs and elder network, to promote collaborations across all relevant state, municipal and local agencies. In supporting transportation services that address elder needs, Elder Affairs' advocacy efforts for the design of streets that are safe for all ages and abilities, including promoting "Complete Streets", will ensure that the needs of elder users are taken into account across all stages of a transportation projects' implementation. This effort comes to the forefront as the Community First initiative supports frail elders living in their homes and community settings for as long as possible, and in so doing, requires accessible, dependable and affordable transportation services to support their efforts.

Aging and Disability Resource Centers

The Aging & Disability Resource Center program (ADRC) began in 2002 as a jointly sponsored national initiative funded by the Administration on Aging and the Centers for

Medicare and Medicaid Services (CMS). The mission was to create a visible resource in the community that provides a coordinated system of information and access to long-term services and supports for individuals, family members and providers, regardless of age, disability or income.

In 2003, Massachusetts was one of the first 13 states funded to develop an ADRC model. From its inception, the Massachusetts model has been a collaborative effort between the aging network - Aging Services Access Points (ASAPs) and Area Agency on Aging, and the disability network - Independent Living Centers (ILC) as the cornerstone agencies, as well as Executive Office of Elder Affairs and the Mass Rehab Commission on the state level.

As of January 31, 2009, the eleven ADRCs in Massachusetts (Greater North Shore, Merrimack Valley, Central Mass, Pioneer Valley, Berkshire County, Southern Mass, Southeastern Mass, Cape and the Islands, Suffolk County, and Greater Boston) were formally recognized by the Elder Affairs and the Massachusetts Rehabilitation Commission (MRC) through a Memorandum of Understanding (MOU). In signing the MOU, the ADRCs agreed to a set of principles and functions:

- Provide comprehensive information, referral & assistance and follow-up;
- Actively conduct public awareness of both public and private long-term support options, as well as awareness of the ADRC partners, especially among underserved populations;
- Assist consumers to obtain access to public and private programs including chronic disease self-management and other evidenced-based programs that promote the consumer's health and independence in a timely and efficient manner;
- Provide accurate and comprehensive long term care options counseling in accordance with Elder Affairs' Program Instruction EA-PI-05 dated June 10, 2008;
- Build strategic partnerships with Councils on Aging, Executive Office of Health and Human Services' agencies, including the Department of Public Health, community and mental health programs, local public health departments/boards, veterans agencies, the Alzheimer's Association, and other community agencies;
- Promote self-directed care; and
- Identify and plan for existing and future community-based long term care services that can help adults remain in the community, regardless of age or disability.

In addition, the MOU commits the ADRCs to develop relationships with critical pathway providers such as hospital and nursing facility discharge planners, support the implementation of nursing home diversion efforts, and establish advisory boards.

The 11 ADRCs are in very different points in their development. A key objective of the AoA Nursing Home Diversion Grant received in October 2008 is to assist the ADRCs to achieve AoAs vision of being fully functional. To be considered fully functional, the ADRC has to have at least the following:

- An active outreach and marketing plan that targets culturally diverse, un-served and underserved population, their family caregivers, and the professionals who serve them;
- A comprehensive resource database that includes public and private resources;
- An options counseling program;
- Referral protocols to appropriate resources and a mechanism to provide active follow up;
- Formal linkages with critical pathway providers;
- Robust partnerships;
- Clear performance goals and indicators; and
- Adequate capacity to assist consumers in a timely manner.

The Nursing Home Diversion Grant provided funds for the ADRCs to engage in four activities toward becoming fully functional during the next 12 months:

1. Establish a local ADRC coordinator.
2. Build strategic partnerships with Councils on Aging, EOHHS agencies, DPH, community and mental health programs, local public health departments/boards, veterans agencies, the Alzheimer's Association, and other community agencies.
3. Establish a structure to support the long term care options counseling program in accordance with protocols and procedures established by the Executive Office of Elder Affairs and the Massachusetts Rehabilitation Commission.
4. Develop plans to identify individuals not eligible for MassHealth but who are at-risk of Medicaid spend down, working with other community stakeholders to ensure that referrals are made to the ADRCs for that purpose.

Specific strategies that will be used include:

- Establish a structured, effective long term care options counseling program throughout the state.
- Expand and strengthen collaboration and partnerships across public and private sector in the local regions. Expanding partnerships to enable the ADRCs to tap into more constituencies, leverage resources, and craft more effective plans to deal with future long term needs.
- Form an engaged statewide leadership group that includes diverse representatives for disability and elder organizations and agencies.
- Have ADRCS become integral components of new long term care and nursing home diversion initiatives such as waivers for mental health and developmentally disabled populations.

- Develop a robust state-wide accessible resource database where consumers can locate timely, comprehensive information in an efficient manner.

In 2009 Elder Affairs applied for and received a grant from the Administration on Aging through the Medicare Improvement for Patients and Provider Act. Funding will be provided to Aging and Disability Resource Consortiums (ADRCs), Area Agencies on Aging (AAA), and the SHINE (SHIP) Program to train and educate professionals and Medicare beneficiaries about the Low Income Subsidy (LIS), Medicare Savings Programs (MSP) and Medicare Part D. All funds from this grant will be filtered through the state SHINE office and designated amounts will be distributed to the ADRCs that are in areas of the Commonwealth with the highest concentration of beneficiaries who may be eligible for LIS and MSP. The ADRCs along with their partners will reach out to their client base and other individuals who may qualify for these programs. The ADRCs will be required through their contract with Elder Affairs to provide mini-grants to their partners. In addition, through a Memorandum of Understanding, the ADRCs will require that their community based partners conduct outreach and educational events as well as assist with application completion.

Housing and Home Ownership

The Housing & Assisted Living Residence (ALR) Programs administered by Elder Affairs develop strategies to increase housing options and services for eligible seniors and people with disabilities. The Housing group increases access to affordable housing and ensures the quality of supportive housing services.

Elder Affairs goals relating to housing include:

- Diversifying and strengthening options in the "housing with supports" continuum to make "Community First" a reality, and
- Building greater capacity in Home and Community Based services to provide consumers with access to a full array of social support services in the settings of their choice.

Strategies for increasing access to quality elder housing services across the Commonwealth include the following:

- Develop a mechanism to deliver services in an array of residential settings.
- Review and evaluate Congregate Housing program best practices, service gaps and unit upgrades.
- Work with the Department of Transitional Assistance and University of Massachusetts to redefine rest homes and ensure strengthening and sustaining rest homes as a housing model.
- Review and evaluate Supportive Housing residents receiving service coordination who are nursing-facility eligible adults, and those who extend their residency at

supportive housing at least 12 months through receipt of Home Care services and supports.

- Review and evaluate Homelessness Prevention Services and Home Care Programs to broaden capacity to serve elders and those disabled who are at risk of eviction.
- Address potential homelessness by seeking to transition clients to private residences within Supportive, Congregate or Assisted Living Housing Programs.
- The Assisted Living Certification Unit continues to conduct routine certification site visits of all ALRs, as well as investigations when necessary, and monitors ALR incident reports. The certification process is a balance that recognizes the residential model of privacy, autonomy, and individual rights, but also provides oversight to help ensure frail elders' needs and rights are addressed.

Long Term Care Options Counseling Program

A new program being tested at Elder Affairs in collaboration with the Massachusetts Rehabilitation Commission known as the Long Term Care Options Counseling Program (LTCOC) is a service provided by the Aging and Disability Resource Consortiums. The LTCOC program provides elders and individuals with disabilities with the information and support they need to make an informed choice about their long term care support services. The Options Counselor provides unbiased information, reviews options, and supports the individual in determining a plan for service and the steps to achieve it to allow the consumer to live in the setting of choice. Although similar services have been provided through the aging and disability networks in the past, the state is working on addr essing the gaps in the current long term care delivery system to ensure that a more uniform approach is implemented and consumers receive access to the full menu of available long term care services available to them.

Currently, the Massachusetts LTCOC model is being tested in 3 ADRCs in the state: Merrimack Valley, the Greater North Shore and Metro-west. To lay the foundation for the program, staff in the ASAP and ILC test sites have strengthened their partnerships at the community level and developed relationships with select health care providers such as skilled nursing facilities and local hospitals in their region in an effort to promote the LTCOC program and to generate referrals to the designated ADRC sites who provide LTCOC counseling. In developing the design principles for the LTCOC test pilot, designated options counselors and agency staff completed a training curriculum provided by the state prior to offering counseling services beginning in November 2008. LTCOC is currently being offered to individuals in their homes, in hospitals, rehabilitation centers and nursing facilities. Since the program's inception, the ADRCs in the test sites have delivered counseling services to 308 individuals and provided 229 face-to-face meetings and 232 telephone sessions.

The state plans a systematic expansion of the program to ensure access on a statewide basis beginning with those ADRCs that have demonstrated a readiness to implement LTCOC within their agencies. Over the next year, the state will continue to work with each regionally based ADRC to ensure that they meet an established set of criteria to begin options counseling services within their respective regions.

Mental Health Collaborations

Elder Affairs is working to improve access to mental health services as well as coordination and integration among mental health and elder support services so that mental health treatment and supports become more available and more flexibly tailored to meet an elders needs. Our goal is to prevent worsening frailty and functional disability for individual elders and to delay or prevent nursing facility admission or hospital admission for elders with mental illness.

Situations such as declining health, isolation and grief can be significant determinants of depression in elders. Programs that can support outreach, home based counseling, and/or medication administration and management may be able to engage an elder in preventive assistance prior to problem escalation. Elder Affairs funded four pilot programs mid-way through FY 07, all of which are continuing this year. These programs included two models of in-home counseling and engagement, one medication administration program, and a statewide training initiative. In May 2007, Elder Affairs and the Department of Mental Health signed a Memorandum of Understanding outlining areas of mutual concern and collaboration commitments on issues related to elder mental health. Efforts to create more formal linkages between the ASAP/AAAs and DMH Area Offices at the local level are currently underway.

Goal Number Three. Promote Financial Well Being and Healthy Aging . In promoting financial well being, Elder Affairs presents Consumer Directed Care, the EOHHS Long-Term Care Financing Advisory Committee, and Workforce Development as models toward promoting elder independence. Employment, volunteerism, fiscal management development and alternative service opportunities support elders living and thriving in their communities. While Healthy Aging is a core value that runs throughout the State Plan, the Healthy Aging and Falls Prevention Programs focus area presents efforts to have elders take charge of their health.

Consumer Directed Care

Elder Affairs has moved forward from the State Plan on Aging, 2006-2009, discussion regarding Consumer Directed Care, toward encouraging consumers to become more aware of what they are spending and to take a more active role in making care decisions.

Elder Affairs reconstituted the Consumer Directed Care Work Group to finalize the design of the consumer directed option in the state-funded home care programs. This option will permit all elders receiving home and community based services through Home Care Basic and Enhanced Community Options Program (non-waiver) to recruit, hire, and train their own workers to provide assistance with activities of daily living. Consumers who choose this service delivery option will have increased control over when and how they receive services. Care advisors will assist them in understanding how to be an employer and provide skills training related to employer functions. Additionally, the care advisor will administer an assessment to determine if the elder requires assistance in carrying out any of the responsibilities associated with being an employer.

Elders requiring such assistance will have the opportunity to designate a friend or family member as a "surrogate," who will be responsible for assisting in the management of payroll, as well as recruiting, hiring, and supervising workers. Effective August 1, 2009, all 40,000 elders in the home care programs will be offered this option as an alternative to agency services.

In addition, Elder Affairs, in conjunction with one of its home care programs, is implementing a pilot program for an alternative assessment and intervention program for serving nursing home eligible non Medicaid elders. Using the principles and values of self-determination and person-centered planning, this program provides an alternative option for elders who are nursing home eligible to direct their services and supports. In this Person Centered Options program, the person has an annual individual budget allocation and has the ability to purchase goods and services that are not limited to the traditional home care program eligible services. Results from this pilot will be used to inform the expansion of consumer directed services in the Elder Affairs enhanced home care program.

Massachusetts continues to explore opportunities to increase consumer control over the delivery of services. In pursuit of this, Elder Affairs received a grant from AoA in collaboration with the Veterans Health Administration to develop an individual budgeting program for veterans at nursing facility level of care who require community based services. Elder Affairs created the Veterans Independence Plus (VIP) Program, which began enrolling veterans in June 2009. The Veterans Administration Medical Center in Bedford, MA provides a monthly allocation that the veteran may use to meet his/her needs to maintain community independence and avoid nursing facility placement. A care advisor makes quarterly home visits to assess and to help the veteran and family with service plan implementation and the coordination of care. Elder Affairs' experience in the pilot program above and the VA program will form the basis of an individual budgeting option to be offered to all ECOP participants.

Over the past few years, as Massachusetts has continued to rebalance long-term care expenditures as part of its Community First initiative, many more elders have been able to remain in their homes and communities with services as an alternative to nursing home care. As not all elders will choose the consumer directed or individual budgeting options, Elder Affairs recognizes the importance of incorporating basic principles of consumer control into traditional service delivery. To extend the scope of consumer direction, Elder Affairs is working to create a training module for provider agencies that prepares homemakers, personal care workers, and other in-home staff to be responsive to the individual preferences of consumers. A review of programs, regulations, services, and care management protocols will ensure that elders have freedom to control how their care is coordinated and delivered to the greatest extent possible.

In moving forward with Community First, Elder Affairs will continue to increase consumer control and develop its programs to meet the more complex needs of community-based elders.

EOHHS Long-Term Care Financing Advisory Committee

Under the auspices of Governor Patrick's Administration Community First Olmstead Plan, the Executive Office of Health and Human Services (EOHHS) is convening a Long-term Care Financing Advisory Committee to identify strategic options for the future financing of care for elders and individuals with disabilities in Massachusetts. The overall goal of the Advisory Committee is to make recommendations to the Administration regarding a multi-year process of reform.

The Advisory Committee will:

- Advise the state regarding public and private long-term care financing options that will support elders and people with disabilities in a manner that:
  - Maximizes independence;
  - Assures access to the necessary continuum of long term supports; and
  - Supports a sustainable mix of personal and familial responsibility, private financing mechanisms, and public assistance;
- Identify strategic concerns regarding long-term care development and reform including:
  - Parameters of long-term care populations and their service needs;
  - Features of the evolving long-term care system, its financial drivers, and the roles and risks of consumers, providers, and payers;
  - Considerations regarding public financing expansions;
  - Opportunities for private financing mechanisms; and
  - Intersections between the public and private financing roles;
- Identify and prioritize near-term and longer-term policy development options that the state should consider in building a roadmap for change.

The Advisory Committee will meet for 12 months, having started in January 2009. The Committee will begin its work by reviewing the current long term care financing landscape locally and nationally. An assessment of the profile of long-term care populations here in Massachusetts will provide the backdrop for considering both the current patchwork of support, predominantly family caregivers and public financing, and the future opportunities for innovation in both public and private arenas.

The 26-member Committee is made up of a diverse group of talented experts and community representatives. The group will be convened by leadership of EOHHS and the Executive Office of Elder Affairs. The Committee's work will be supported, in part, by the University of Massachusetts Medical School, Commonwealth Medicine and the Massachusetts Medicaid Policy Institute. A report produced by the Committee entitled Long-Term Care in Massachusetts: Facts at a Glance can be found by following the link, www.mass.gov/Eeohhs2/docs/eohhs/ltc_factsheet.pdf.

Workforce Development

Elder Affairs maintains its management of the Senior Community Service Employment Program (SCSEP) as the principal strategy in promoting engagement of older adults in employment by both public and private employers.

The goal of the SCSEP program is to place eligible applicants in nonprofit or public/community service host agencies, where they receive on-the-job training for up to 20 hours per week. Participants are paid at least the current minimum wage during their temporary assignments and work with SCSEP to locate permanent part-time or full-time employment. Participants benefit from SCSEP in many ways, including:

- Receiving assistance in developing job search skills and in locating a permanent job;
- Obtaining paid work experience to improve job skills, while also developing new skill capacity;
- Establishing a current work history and an up-to-date resume;
- Paid sick leave and paid Federal and State holidays;
- Worker's compensation insurance; and,
- A yearly physical examination.

As the ultimate goal of the program is to provide the participant with the tools necessary to obtain unsubsidized employment, Elder Affairs collaborates with the One Stop Career Centers and the Massachusetts Executive Office of Labor Workforce Development to provide additional training and employment options counseling for participants.

Due to the shifting demographics within Massachusetts, the future economic and civic well-being of the Commonwealth depends in large measure upon how well we succeed in increasing the continuing employment, civic engagement, and volunteerism of experienced adults.

In promoting workforce development beyond SCSEP, Elder Affairs formed in August 2008 a new coalition, the Massachusetts Partnership for Promoting the Civic Engagement and Employment of Older Adults (The Partnership), to work with the National Governors' Academy (NGA) for Civic Engagement to spur more employers to recruit and retain older adult workers and to improve the ways community agencies recruit, develop and utilize older adult volunteers. To achieve these goals, Elder Affairs will implement a comprehensive strategy to both increase the engagement of older adults in employment and civic life, and build a more robust volunteer recruitment and management system.

The Partnership is led by a coalition of leaders from Elder Affairs, the Executive Office of Labor and Workforce Development, the UMASS McCormack Institute of Public Policy, the Governor's Office of Civic Engagement, the Massachusetts Rehabilitation Commission, the Commonwealth's Human Resources Division, the Massachusetts Service Alliance, the Massachusetts Association of Councils on Aging and Senior Centers, the Commonwealth Corporation, and AARP Massachusetts. With NGA assistance, the Partnership will use the

experience of other states to guide us as we develop strategies to increase the number of older adult workers who are engaged in work, civic life, and volunteer service. The identification of two main spheres of interest, employment and volunteerism, has been determined by the Partnership as challenges toward implementing strategies for workforce development.

As identified by the Commonwealth Corporation in May 2008, roughly 40% of Massachusetts' overall workforce is over the age of 45. This poses significant challenges to employers as their most skilled and experienced workers reach retirement age. To help businesses address this challenge, the objectives of the Partnership relating to increasing employment include:

- Increasing access to computer fluency skills training and job search techniques training through developing new workshops at Councils on Aging and for community television programming;
- Providing outreach to employers to understand the value of the older work force, the shifting demographic reality that will result in all labor force growth limited to adults age 55 and older, and providing easy access to technical tools and guidance on which HR policies will help retain and attract older workers;
- Developing and promoting use of a new Google Transit trip planning toolkit for mapping out routes using just public transportation; and
- Designating public computer kiosks at each COA that will provide easy links to 5 destinations, including local One Stop Career Centers, and job search techniques training and job banks, volunteer opportunities match sites, life long learning programs, benefits information and a new public transportation trip planning tool.

The Partnership has also identified volunteerism as a second challenge in implementing workforce development for older adults. Older adults, especially Baby Boomers, represent a valuable potential staffing resource to the non-profit world, not only because of the sheer size of the generation but also because of its members' high levels of education and skills. It is important for organizations who rely upon volunteers to understand not only how best to capture their experience and energy, but also what factors will impact their decision to keep volunteering and contributing to civic life from year to year. The objectives of the Partnership relating to increasing volunteerism include:

- Promoting the Massachusetts Service Alliance's web-based volunteer recruiting site, "Connect and Serve", to help both organizations seeking volunteers and individuals looking for interesting volunteer roles;
- Developing within every municipal Council on Aging lists of local volunteer opportunities/organizations that hire volunteers – to help match adults with service goals that interest them the most;
- Building a network/coalition of organizations that are currently engaging older adults as volunteers to share best practices; and

- Offering training on volunteer recruitment and retention management best practices that will help local organizations rethink how to attract and deploy older adults as volunteers.

As part of our work in 2009 and 2010, the Partnership will inventory potential state policy changes that could be implemented via executive orders, legislation, policy and/or regulatory change that would reduce barriers to and/or promote employment and civic engagement for midlife and older adults. In 2010 and beyond, we shall create and execute a strategically coordinated and multi-tactic awareness campaign, about the advantages of and best practices for successfully engaging older individuals in civic life, volunteer service and employment.

Healthy Aging and Falls Prevention Programs

Chronic diseases affect over eighty percent of adults age 60 and older. Many chronic conditions are preventable, treatable, or manageable. Elder Affairs and the Massachusetts Department of Public Health, in conjunction with Elder Services of Merrimack Valley, Action for Boston Community Development and Hebrew Senior Life, help community-based organizations offer programs that give participants the tools to take charge of their health.

The three programs discussed in the earlier section, "Health Care System Coordination" (Healthy Eating for Successful Living in Older Adults, My Life, My Health: Chronic Disease Self-Management Program and A Matter of Balance), are being disseminated throughout Massachusetts, and provide a continuum of opportunities to promote healthy aging. Specifically targeted are Councils on Aging and senior centers, Area Agencies on Aging, elderly nutrition programs, family caregiver support programs, community health centers, Title V Senior Community Service Employment Programs (SCSEP), independent living centers, health care insurers, Medicaid and public health programs. The goal is to reach 80% of the state's communities with these evidence based-programs by 2013.

The AAA network in Massachusetts is at the forefront of adopting evidence-based disease prevention programs in empowering older people to be able to easily access existing health care options. Many of the twenty-three AAAs are operating or are in the process of adopting the three programs above toward promoting healthy aging. In addition, the results of the Massachusetts 2009 Needs Assessment Study indicate the importance of promoting healthy aging through physical activities, fitness and recreation including injury/falls prevention programs. Elder Affairs supports the AAAs in promoting community-based healthy lifestyle choices and programs; some approaches include:

- Promoting evidence-based disease prevention programs through public access events including, web-site offerings, television and cable promotions, community newspaper articles, and speakers' bureaus.
- Providing opportunities for leading healthy lifestyles through the delivery of nutritionally sound congregate and home delivered meals, and in so doing, set in motion possibilities for fall prevention.

- AAAs continuing to commit to providing educational sessions for congregate and home delivered meals participants on nutrition choices in order to facilitate healthy aging.
- Promoting the benefits of fresh produce through the distribution of farmer's market coupons through each of the twenty-seven Nutrition Programs in Massachusetts. Many Programs also purchase fresh produce for distribution to home delivered meals participants.
- AAAs advancing fall prevention through programs that encourage elders to be aware of fall prevention protocols, factors contributing to increased risk of falls and home environment changes to lessen potential fall risks. Exercise programs for improving strength are also part of this effort.
- Elder Affairs distributing various "health prevention" materials to alert community consumers on ways to promote health maintenance and disease management. Booklets, pamphlets, brochures, etc. are available to be mailed to any consumer requesting information on a certain topic area. Information on falls prevention is available online and pamphlets on this issue can be sent to consumers who are requesting more detailed information on how to avoid falls and implementing safety tips at home.
- The Elder Affairs I&R staff members serving on the Massachusetts Falls Prevention Coalition. The mission of the Coalition is to promote healthy lifestyles, behaviors and strategies to prevent falls and fall-related injuries across the lifespan in Massachusetts through collaboration and training of individuals transitioning from one setting to another.
- Collaborations between AAAs and local providers to support complete home assessments for blind and low-vision elders in efforts to prevent falls.
- Supporting healthy aging through community participation in local health fairs, flu vaccination clinics, local housing assemblies, and other public health conferences and events aimed at healthy aging.
- Elder Affairs working on a strategy with the Executive Director and Program Director of the Massachusetts Association of Community Health Centers (MACHC) to increase the number of seniors receiving medical care from community health centers - a response primarily to the changing demographics in the state. In addition, the MACHC Program Director is now a member of the statewide geriatric mental health consortium co-led by Elder Affairs and Department of Mental Health.

Appendix A: Verification of Intent

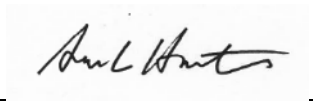
Verification of Intent

The Massachusetts Executive of Elder Affairs State Plan on Aging is hereby submitted for the Commonwealth of Massachusetts for the period October 1, 2009, through September 30, 2013. Included are all assurances and activities to be implemented by the Executive Office of Elder Affairs under provisions of the Older Americans Act of 1965, as amended .

As the authorized and designated State Unit on Aging in Massachusetts and in assuming the roles and responsibilities as such, the Executive Office of Elder Affairs is responsible for developing the Massachusetts State Plan on Aging in accordance with the Older Americans Act and associated regulations, policies and procedures as outlined by the Administration on Aging. The Plan addresses Elder Affairs' role as the leader relative to aging issues on behalf of all older persons in Massachusetts. Each program managed at Elder Affairs, along with each unit within the agency plays a role in the administration and delivery of services to elders and their caregivers and in so doing, supports the State Plan on Aging.

The Massachusetts State Plan on Aging for Federal Fiscal Years 2010 through 2013 is hereby submitted and has been developed in accordance with all federal statutory and regulatory requirements.

I hereby approve this Plan as His Excellency; Deval L. Patrick's designee and submit it for approval to the Assistant Secretary for Aging, Administration on Aging, U.S. Department of Health and Human Services.

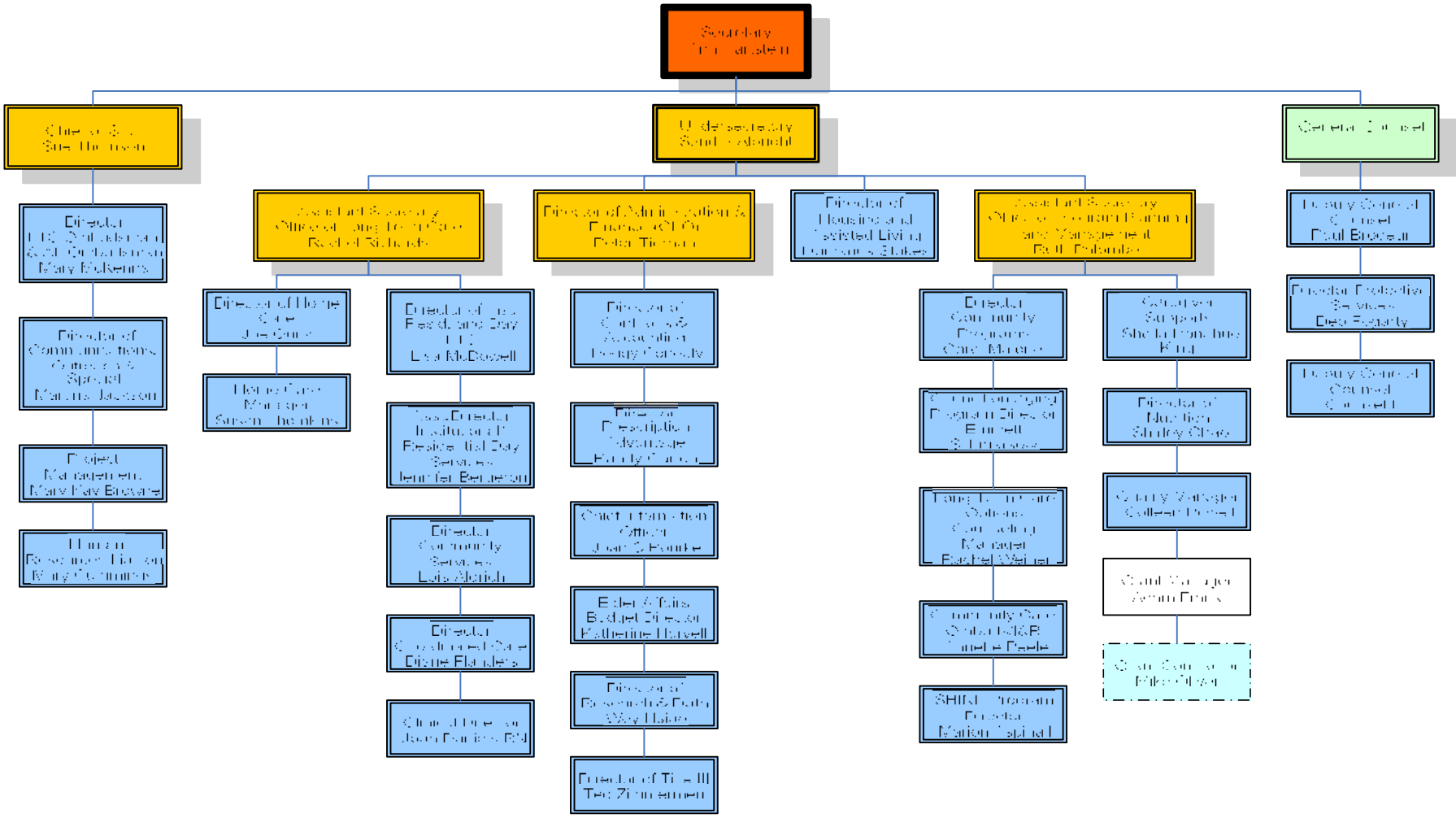


August 21, 2009

Ann L. Hartstein, Secretary
Executive Office of Elder Affairs
Commonwealth of Massachusetts

Date

Appendix B: Elder Affairs Organizational Chart - 2009



Appendix C: State Plan Assurances and Activities

The Secretary of the Executive Office of Elder Affairs, as the official signato ry for the Office, hereby commits the State Unit on Aging to performing the following listed assurances and required activities and procedures.

Highlighted Assurances and General Activities

State Unit on Aging Compliance. In accordance with the Older Am ericans Act of 1965, as amended, the Executive Office of Elder Affairs (Elder Affairs) has been designated the State Unit on Aging within the Commonwealth of Massachusetts. In that capacity, Elder Affairs accepts the responsibility as the lead agency in M assachusetts for planning, policy development, administration, coordination, priority setting, and evaluation of activities related to the objectives of the Older Americans Act.

State Plan Development. In assuming the role as the State Unit on Aging, E lder Affairs is responsible for developing the Massachusetts State Plan on Aging in accordance with the Older Americans Act and associated regulations, policies and procedures as outlined by the Administration on Aging. The Plan addresses Elder Affairs' r ole as the leader relative to aging issues on behalf of all older persons in Massachusetts. Each program managed at Elder Affairs, along with each unit within the agency plays a role in the administration and delivery of services to elders and their careg ivers and in so doing, supports the State Plan on Aging. Additionally, Elder Affairs is aware of our responsibility to amend the Massachusetts State Plan in accordance with Title III regulations that would necessitate such changes.

Solicitation of Service Recipient Views. The Executive Office of Elder Affairs (Elder Affairs) and the twenty-three Area Agencies on Aging (AAAs) in Massachusetts have continued the longstanding practice of soliciting opinions and perspectives from service recipients through the 2009 Needs Assessment Study. The primary level of the 2009 Study solicited views from more than 6,225 elders and their stakeholders through participation in 206 single-and multiple-day need assessment events conducted by the AAAs from October 2007 through December 2008. The decentralized approach provides crucial input for AAAs as they plan for and prepare the 2010-2013 Area Plans, and in turn facilitates Elder Affairs' development of the State Plan.

Client Preference and Participation. The State agency preserves the Older Americans Act mandate that funding be made available for the provision of services to persons sixty (60) years of age or older with preference in service delivery to older persons in greatest social or economic need, with particular attention to older individuals with limited English proficiency, and elder living in rural areas. Additionally, services under Title III programs are provided by the Area Agencies on Aging without use of any means test.

Multigenerational Service Activi ties. Elder Affairs and the Area Agencies on Aging maintain efforts to address the connection between generations that is crucial in supporting vibrant communities. Activities of this nature include classroom reading assistance, intergenerational computer training, veterans' visits to schools, and other ad hoc events. Family support programs, including the Grandparents and Other Elderly Caregivers Serving

Children program within the Title III-E program provides for older individuals to share life experiences and advice with younger generations.

Public Engagement. The Executive Office of Elder Affairs recognizes the importance of including the views of older persons and the public in developing and administering elder services under the State Plan. We continue to engage public comment in our goal to stimulate the development and continued enhancement of comprehensive and coordinated community-based systems for services and programs for the elderly in Massachusetts. In coordination with and support of the twenty-three Area Agencies on Aging in Massachusetts, Elder Affairs encourages public and professional participation using a number of methods that includes a range of stakeholders, including:

- The 2009 Massachusetts Needs Assessment Survey – Municipal Survey
- The 2009 Massachusetts Needs Assessment Survey – Provider Survey
- The 2009 Massachusetts Needs Assessment Survey – General Public Survey
- Area Agency on Aging Community Focus Groups
- Community Presentations by Elder Affairs' personnel
- Elder Affairs Community Connection Series (2008/2009)
- Elder Affairs "Senior Scene" Cable Program
- Elder Affairs Senior Benefits Expo Presentations
- Executive Office of Health and Human Services Community Forums (2009)
- Interaction with and response to public input through the departments' Information and Resources Department through the administration of 1-800-AGE-INFO

Development and Implementation of Area Plans. The twenty-three AAAs in Massachusetts have a long history of developing, designing and implementing programs and services for elders and their caregivers. Elder Affairs provides assurance that each of the AAAs in Massachusetts is capable of developing and implementing an Area Plan on Aging and meets the requirements and demands required of a designated Area Agency on Aging. In providing services to elders and caregivers in their designated Planning and Service Area, each of the AAAs offers a comprehensive array of programs and services that address elder needs through the design and implementation of the Area Plan.

Priority Services. As required under the Older Americans Act, Section 307 (a)(2)(C), Elder Affairs has established a minimum proportion of the funding received by each Area Agency on Aging in the state under Part B of the Act, be mandated for the provision of certain priority services; access, in-home and legal services. As part of the annual monitoring review, Elder Affairs confirms that each AAA meets the priority services requirements as assigned. The following indicates the minimum funding percentages for priority services.

Access Services	two (2) percent of Part B funding available.
In-home Services	two (2) percent of Part B funding available.
Legal Services	eight (8) percent of Part B funding available.

The figure for legal services is based on a minimum standard plus an individual maintenance of effort required separately of each Area Agency on Aging.

Voluntary Contribution Policy. In connection with the voluntary contribution policies as outlined in 45 CFR 1321.67, Elder Affairs has established guidelines and methods to ensure that Area Agencies on Aging have instituted policies and approved procedures that address the proper observances to client confidentiality and the voluntary nature of solicited client contributions.

Fiscal Control and Compliance with Grant Requirements. Elder Affairs is attentive and accountable for assuring compliance with programmatic reports required under the plan. Additionally, the State agency is responsible for maintaining appropriate fiscal control and accounting procedures as outlined in the agency's Internal Control Plan as a means to provide accountability, encourage management practices, and facilitate audit preparation. The State Unit on Aging pledges that no individual at the State or AAA level is subject to a conflict of interest prohibited under the Older Americans Act. Moreover, external controls provide oversight in ensuring that proper procedures and policies are maintained, and include the following State agencies:

Executive Office of Administration and Finance
Executive Office of Health and Human Services
Operational Services Division
State Comptrollers Office
Auditors Office
Fiscal Affairs Division
Human Resources Division
Information Technology Division
Treasurers Office

The fiscal operations of the AAAs are in compliance with all government regulations, including:

Commonwealth of Massachusetts Standard Terms and Conditions
Older Americans Act of 1965, as amended
OMB Circular A-122, Cost Principles for Non-Profit Organizations
OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations
45 CFR 74, Uniform Administrative Requirements for Awards and Subawards to Non-Profit Organizations
45 CFR 1321, Grants to State and Community Programs on Aging

Additionally, Elder Affairs maintains that each AAA has designed and maintains a system of internal control and that standards have been designed to ensure appropriate spending, recording and reporting of expenditures and revenues by AAAs as well as subgrantees and providers.

Legal Assistance Services. Each of the AAAs in Massachusetts is required to contract with Legal Assistance Providers to confer assistance in legal matters for individuals sixty (60) years of age or older. Priority in service provision is given to older persons with the greatest economic and social need with particular attention to low-income minority individuals and those residing in rural areas. Additionally, the AAAs are required to collaborate with Legal Services Providers in an effort to reach out to the private bar in offering services to elders on a pro bono and reduced fee basis.

Statewide non-Federal Share Requirements. Elder Affairs is cognizant of the distinct non-Federal match requirements established under the Older Americans Act and has established mechanisms to track and report match reported at both the State and Area Agency

levels. Area Agencies on Aging meet match requirements under the various Title III service categories using a variety of funding sources, including, but not limited to; state appropriated funds, county and city government funds, fund raising activity funds, in -kind resources and other local sources of funding.

State Agency Maintenance of Effort. The Executive Office of Elder Affairs meets or exceeds the required non-federal share for both services and administration of State funds under the State Plan as required by Title III regulations and Administration on Aging directives. Annual statements submitted to the Administration on Aging validate this assurance.

Confidentiality and Disclosure of Information. The State Agency has implemented policies, procedures, guidelines and training presentations in support of maintaining client confidentiality for persons receiving services under Title III, including the special concerns for those clients receiving legal services. Furthermore, Elder Affairs requires that Area Agencies on Aging are ensuring that relevant or affected service provider's are cognizant of and compliant with relevant provisions of the Healt h Insurance Portability and Accountability Act (HIPAA) of 1996.

Evaluation and Monitoring of Programs. The Department continues to conduct monitoring reviews of Title III funded programs and their administration as performed by Area Agencies on Aging. The establishment of the Elder Affairs' monitoring tool, Standards and Indicators – Title III Programs, continues to set the benchmark for high quality operation of Title III Programs and menus of activities in support of achieving them. The monitoring and evaluation process serves to meet requirements under the Older Americans Act as well as providing a means and method for Area Agencies on Aging and Elder Affairs to directly partner and cooperate toward achieving the best quality of services for the Commo nwealth's elders.

Quality Improvement Methods. Elder Affairs' quality management strategy is designed to assure that essential safeguards are met with respect to health, safety and quality of life across the span of managed programs. The use of data an d related information is necessary to promote ongoing quality improvement efforts. While there are multiple approaches in place to allow for a robust system, the overall quality management and improvement system continues to evolve and improve. The quali ty management and improvement strategy is based on the following key operational principles:

- The system is designed to create a continuous loop of quality including the identification of issues, notification to concerned parties, correction/remediation, follow-up analysis of patterns of trends and service improvement activities.
- Quality is measured based upon a set of outcome measures agreed upon by stakeholders, which are based on EOHHS and Elder Affairs mission statements, CMS assurances, Commonwealth of Massachusetts' regulations, and quality reports and related findings.
- The system measures health and safety for elders and also places a strong emphasis on other quality of life domains including participant access, person -centered

planning and delivery, qualified providers, rights and responsibilities and participant satisfaction.

Elder Affairs Quality Management and Improvement System approaches quality from three perspectives: the individual, the provider and the system. On each tier the focus is on the discovery of issues, remediation and service improvement.

Direct Service Provisions and Case Management Services. Elder Affairs assures that no supportive services, nutrition services, or in-home services are provided directly by the State agency or an Area Agency on Aging unless the provision of such services meets the conditions as delineated within the Older Americans Act. Additionally, Area Agencies on Aging providing case management services under State sponsored programs are maintained and continue throughout the period of the 2010-2013 State plan. Area Agencies on Aging provide case management services to clients that include a comprehensive, interdisciplinary needs assessment and the development of a care plan to address the documented needs of clients. Elder Affairs also allows Area Agencies on Aging to directly provide information and assistance services and outreach services.

Older Americans Act Assurances

Section. 305. Organization

(a) In order for a State to be eligible to participate in programs of grants to States from allotments under this title—

(1) the State shall, in accordance with regulations of the Assistant Secretary, designate a State agency as the sole State agency to—

(A) develop a State plan to be submitted to the Assistant Secretary for approval under section 307;

(B) administer the State plan within such State;

(C) be primarily responsible for the planning, policy development, administration, coordination, priority setting, and evaluation of all State activities related to the objectives of this Act;

(D) serve as an effective and visible advocate for older individuals by reviewing and commenting upon all State plans, budgets, and policies which affect older individuals and providing technical assistance to any agency, organization, association, or individual representing the needs of older individuals; and

(E) divide the State into distinct planning and service areas (or in the case of a State specified in subsection (b)(5)(A), designate the entire State as a single planning and service area), in accordance with guidelines issued by the Assistant Secretary, after considering the geographical distribution of older individuals in the State, the incidence of the need for supportive services, nutrition services, multipurpose senior centers, and legal assistance, the distribution of older individuals who have greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas residing in such areas, the distribution of older individuals who have greatest social need (with particular

attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such areas, the distribution of older individuals who are Indians residing in such areas, the distribution of resources available to provide such services or centers, the boundaries of existing areas within the State which were drawn for the planning or administration of supportive services programs, the location of units of general purpose local government within the State, and any other relevant factors;

(2) the State agency shall—

(A) except as provided in subsection (b)(5), designate for each such area after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agen cy or organization as the area agency on aging for such area;

(B) provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan;

(C) in consultation with area agencies, in accordance with guide lines issued by the Assistant Secretary, and using the best available data, develop and publish for review and comment a formula for distribution within the State of funds received under this title that takes into account—

(i) the geographical distribution of older individuals in the State; and

(ii) the distribution among planning and service areas of older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority older individu als;

(D) submit its formula developed under subparagraph (C) to the Assistant Secretary for approval;

(E) provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with grea test social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

(F) provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16); and

(G)(i) set specific objectives, in consultation with area agencies on aging, for each planning and service area for providing services funded under this title to low - income minority older individuals and older individuals residing in rural areas;

(ii) provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low -income minority older individuals; and

(iii) provide a description of the efforts described in clause (ii) that will be undertaken by the State agency; and

(3) the State agency shall, consistent with this section, promote the development and implementation of a State system of long-term care that is a comprehensive, coordinated system that enables older individuals to receive long-term care in home and community-based settings, in a manner responsive to the needs and preferences of the older individuals and their family caregivers, by—

(A) collaborating, coordinating, and consulting with other agencies in such State responsible for formulating, implementing, and administering programs, benefits, and services related to providing long-term care;

(B) participating in any State government activities concerning long-term care, including reviewing and commenting on any State rules, regulations, and policies related to long-term care;

(C) conducting analyses and making recommendations with respect to strategies for modifying the State system of long-term care to better—

(i) respond to the needs and preferences of older individuals and family caregivers;

(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and

(iii) target services to individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;

(D) implementing (through area agencies on aging, service providers, and such other entities as the State determines to be appropriate) evidence-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and

(E) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, area agencies on aging, and other appropriate means) of information relating to—

(i) the need to plan in advance for long-term care; and

(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources.

(b)(1) In carrying out the requirement of subsection (a)(1), the State may designate as a planning and service area any unit of general purpose local government which has a population of 100,000 or more. In any case in which a unit of general purpose local government makes application to the State agency under the preceding sentence to be designated as a planning and service area, the State agency shall, upon request, provide an opportunity for a hearing to such unit of general purpose local government. A State may designate as a planning and service area under subsection (a)(1) any region within the State recognized for purposes of area wide planning which includes one or more such units of general purpose local government when the State determines that the designation of such a regional planning and service area is necessary for, and will enhance, the effective administration of the programs authorized by this title. The State may include in any planning and service area designated under subsection (a)(1) such additional areas adjacent to the unit of general purpose local government or regions so designated as the

State determines to be necessary for, and will enhance the effective administration of the programs authorized by this title.

(2) The State is encouraged in carrying out the require ment of subsection (a)(1) to include the area covered by the appropriate economic development district involved in any planning and service area designated under subsection (a)(1), and to include all portions of an Indian reservation within a single planni ng and service area, if feasible.

(3) The chief executive officer of each State in which a planning and service area crosses State boundaries, or in which an interstate Indian reservation is located, may apply to the Assistant Secretary to request re-designation as an interstate planning and service area comprising the entire metropolitan area or Indian reservation. If the Assistant Secretary approves such an application, the Assistant Secretary shall adjust the State allotments of the areas within the planning and service area in which the interstate planning and service area is established to reflect the number of older individuals within the area who will be served by an interstate planning and service area not within the State.

(4) Whenever a unit of general purpose local government, a region, a metropolitan area or an Indian reservation is denied designation under the provisions of subsection (a)(1), such unit of general purpose local government, region, metropolitan area, or Indian reservation may appeal the decision of the State agency to the Assistant Secretary. The Assistant Secretary shall afford such unit, region, metropolitan area, or Indian reservation an opportunity for a hearing. In carrying out the provisions of this paragraph, the Assistant Secretary may approve the decision of the State agency, disapprove the decision of the State agency and require the State agency to designate the unit, region, area, or Indian reservation appealing the decision as a planning and service area, or take such other action as the Assistant Secretary deems appropriate.

(5) (A) A State which on or before October 1, 1980, had designated, with the approval of the Assistant Secretary, a single planning and service area covering all of the older individuals in the State, in which the State agency was administering the area plan, may after that date designate one or more additional planning and service areas within the State to be administered by public or private nonprofit agencies or organizations as area agencies on aging, after considering the factors specified in subsection (a)(1)(E). The State agency shall continue to perform the functions of an area agency on aging for any area of the State not included in a planning and service area for which an area agency on aging has been designated.

(B) Whenever a State agency designates a new area agency on aging after the date of enactment of the Older Americans Act Amendments of 1984, the State agency shall give the right to first refusal to a unit of general purpose loc al government if

(i) such unit can meet the requirements of subsection (c), and

(ii) the boundaries of such a unit and the boundaries of the area are reasonably contiguous.

(C)(i) A State agency shall establish and follow appropriate procedures to provid e due process to affected parties, if the State agency initiates an action or proceeding to—

(I) revoke the designation of the area agency on aging under subsection (a);

(II) designate an additional planning and service area in a State;

(III) divide the State into different planning and service areas; or

(IV) otherwise affect the boundaries of the planning and service areas in the State.

(ii) The procedures described in clause (i) shall include procedures for —

(I) providing notice of an action or proceeding described in clause (i);

(II) documenting the need for the action or proceeding;

(III) conducting a public hearing for the action or proceeding;

(IV) involving area agencies on aging, service providers, and older individuals in the action or proceeding; and

(V) allowing an appeal of the decision of the State agency in the action or proceeding to the Assistant Secretary.

(iii) An adversely affected party involved in an action or proceeding described in clause (i) may bring an appeal described in clause (ii) (V) on the basis of—

(I) the facts and merits of the matter that is the subject of the action or proceeding; or

(II) procedural grounds.

(iv) In deciding an appeal described in clause (ii)(V), the Assistant Secretary may affirm or set aside the decision of the State agency. If the Assistant Secretary sets aside the decision, and the State agency has taken an action described in sub - clauses (I) through (III) of clause (i), the State agency shall nullify the action.

(c) An area agency on aging designated under subsection (a) shall be—

(1) an established office of aging which is operating within a planning and service area designated under subsection (a);

(2) any office or agency of a unit of general purpose local government, which is designated to function only for the purpose of serving as an area agency on aging by the chief elected official of such unit;

(3) any office or agency designated by the appropriate chief elected officials of any combination of units of general purpose local government to act only on behalf of such combination for such purpose;

(4) any public or nonprofit private agency in a planning and service area, or any separate organizational unit within such agency, which is under the supervision or direction for this purpose of the designated State agency and which can and will engage only in the planning or provision of a broad range of supportive services, or nutrition services within such planning and service area; or

(5) in the case of a State specified in subsection (b)(5), the State agency; and shall provide assurance, determined adequate by the State agency, that the area agency on

aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area. In designating an area agency on aging within the planning and service area or within any unit of general purpose local government designated as a planning and service area the State shall give preference to an established office on aging, unless the State agency finds that no such office within the planning and service area will have the capacity to carry out the area plan.

(d) The publication for review and comment required by paragraph (2)(C) of subsection (a) shall include—

(1) a descriptive statement of the formula's assumptions and goals, and the application of the definitions of greatest economic or social need,

(2) a numerical statement of the actual funding formula to be used,

(3) a listing of the population, economic, and social data to be used for each planning and service area in the State, and

(4) a demonstration of the allocation of funds, pursuant to the funding formula, to each planning and service area in the State.

Section. 307. State Plans

(a) Except as provided in the succeeding sentence and section 309(a), each State, in order to be eligible for grants from its allotment under this title for any fiscal year, shall submit to the Assistant Secretary a State plan for a two-, three-, or four year period determined by the State agency, with such annual revisions as are necessary, which meets such criteria as the Assistant Secretary may by regulation prescribe. If the Assistant Secretary determines, in the discretion of the Assistant Secretary, that a State failed in 2 successive years to comply with the requirements under this title, then the State shall submit to the Assistant Secretary a State plan for a 1-year period that meets such criteria, for subsequent years until the Assistant Secretary determines that the State is in compliance with such requirements. Each such plan shall comply with all of the following requirements:

(1) The plan shall—

(A) require each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and (B) be based on such area plans.

(2) The plan shall provide that the State agency will—

(A) evaluate, using uniform procedures described in section 202(a)(29), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) develop a standardized process to determine the extent to which public or private programs and resources (including volunteers and programs and services of voluntary organizations) that have the capacity and actually meet such need; and

(C) specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under section 306(c) or 316) by such area agency on aging to provide each of the ca tegories of services specified in section 306(a)(2).

(3) The plan shall—

(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning intrastate distribution of funds); and

(B) with respect to services for older individuals residing in rural areas —

(i) provide assurances that the State agency will spend for each fiscal year, not less than the amount expended for such services for fiscal year 20 00;

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and

(iii) describe the methods used to meet the needs for such services in the fisc al year preceding the first year to which such plan applies.

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas).

(5) The plan shall provide that the State agency will —

(A) afford an opportunity for a hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issue guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) afford an opportunity for a public hearing, upon request, by any area agency on aging, by any provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under section 316.

(6) The plan shall provide that the State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(7)(A) The plan shall provide satisfactory assurance that such fis cal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(B) The plan shall provide assurances that—

(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;

(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and

(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(8)(A) The plan shall provide that no supportive services, nutrition services, or in-home services will be directly provided by the State agency or an area agency on agi ng in the State, unless, in the judgment of the State agency—

(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such State a gency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

(B) Regarding case management services, if the State agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a State program, the plan may specify that such agency is allowed to continue to provide case management services.

(C) The plan may specify that an area agency on aging is allowed to directly provide information and assistance services and outreach.

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Lo ng-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount t hat is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurances that the special needs of older individuals residing in rural areas will be taken into considerat ion and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11) The plan shall provide that with respect to legal assistance—

(A) the plan contains assurances that area agencies on aging will

(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;

(ii) include in any such contract provisions to assure that any recipient of funds under division (i) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and

(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis;

(B) the plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Lega l Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such n eed; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services;

(C) the State agency will provide for the coordination of the furnishing of legal assistance to older individuals within the State, and provide advice and technical assistance in the provision of legal assistance to older individuals within the State and support the furnishing of training and technical assistance for legal assistance for older individuals;

(D) the plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals; and

(E) the plan contains assurances that area agencies on aging will give priority to leg al assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fis cal year for services for the prevention of abuse of older individuals —

(A) the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for —

(i) public education to identify and prevent abuse of older individuals;

(ii) receipt of reports of abuse of older individuals;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and

(iv) referral of complaints to law enforcement or public protective service agencies where appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in this paragraph by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential unless all parties to the complaint consent in writing to the release of such information, except that such information may be released to a law enforcement or public protective service agency.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and

(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include—

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

(A) identify individuals eligible for assistance under this Act, with special emphasis on—

(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;

(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;

(iv) older individuals with severe disabilities;

(v) older individuals with limited English-speaking ability; and

(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who —

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall—

(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits

provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made—

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

(28)(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—

(i) the projected change in the number of older individuals in the State;

(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how

resource levels can be adjusted to meet the needs of the changing popul ation of older individuals in the State; and

(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services.

(29) The plan shall include information detailing how the St ate will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any oth er institutions that have responsibility for disaster relief service delivery.

(30) The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness pl ans, including the State Public Health Emergency Preparedness and Response Plan.

Section. 308, Planning, Coordination, Evaluation, and Administration of State Plans

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unles s it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not support ed under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Section. 316. Waivers.

(a) IN GENERAL.—The Assistant Secretary may waive any of the provisions s pecified in subsection (b) with respect to a State, upon receiving an application by the State agency containing or accompanied by documentation sufficient to establish, to the satisfaction of the Assistant Secretary, that—

(1) approval of the State legisl ature has been obtained or is not required with respect to the proposal for which waiver is sought;

(2) the State agency has collaborated with the area agencies on aging in the State and other organizations that would be affected with respect to the propo sal for which waiver is sought;

(3) the proposal has been made available for public review and comment, including the opportunity for a public hearing upon request, within the State (and a summary of all of the comments received has been included in the a pplication); and

(4) the State agency has given adequate consideration to the probable positive and negative consequences of approval of the waiver application, and the probable benefits for older individuals can reasonably be expected to outweigh any ne gative consequences, or particular circumstances in the State otherwise justify the waiver.

(b) REQUIREMENTS SUBJECT TO WAIVER. —The provisions of this title that may be waived under this section are—

(1) any provision of sections 305, 306, and 307 requiri ng statewide uniformity of programs carried out under this title, to the extent necessary to permit demonstrations, in limited areas of a State, of innovative approaches to assist older individuals;

(2) any area plan requirement described in section 306(a) if granting the waiver will promote innovations or improve service delivery and will not diminish services already provided under this Act;

(3) any State plan requirement described in section 307(a) if granting the waiver will promote innovations or im prove service delivery and will not diminish services already provided under this Act;

(4) any restriction under paragraph (5) of section 308(b), on the amount that may be transferred between programs carried out under part B and part C; and

(5) the requirement of section 309(c) that certain amounts of a State allotment be used for the provision of services, with respect to a State that reduces expenditures under the State plan of the State (but only to the extent that the non -Federal share of the expendi tures is not reduced below any minimum specified in section 304(d) or any other provision of this title).

(c) DURATION OF WAIVER.—The application by a State agency for a waiver under this section shall include a recommendation as to the duration of the w aiver (not to exceed the duration of the State plan of the State). The Assistant Secretary, in granting such a waiver, shall specify the duration of the waiver, which may be the duration recommended by the State agency or such shorter time period as the As sistant Secretary finds to be appropriate.

(d) REPORTS TO SECRETARY.—With respect to each waiver granted under this section, not later than 1 year after the expiration of such waiver, and at any time during the waiver period that the Assistant Secretary may require, the State agency shall prepare and submit to the Assistant Secretary a report evaluating the impact of the waiver on the operation and effectiveness of programs and services provided under this title.

Section. 705. Additional State Plan Requi rements.

(a) ELIGIBILITY.—In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307 —

(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;

(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;

(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;

(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;

(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);

(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under

chapter 3—

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant

State law and coordinated with existing State adult protective service activities for —

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under th is Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public prot ective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph

(A) by alleged victims, abusers, or their households; and

(C) all information gathered in the co urse of receiving reports and making referrals shall remain confidential

except—

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order; and

(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6).

The Massachusetts Executive Office of Elder Affairs declares that the following assurances will be incorporated into the 2010-2013 Area Plans on Aging, and thus be revealed as required affirmations by the twenty-three designated Area Agencies on Aging in Massachusetts.

Section. 306. Area Plans

(a) Each area agency on aging designated under section 305(a)(2)(A) shall, in order to be approved by the State agency, prepare and develop an area plan for a planning and service area for a two-, three-, or four-year period determined by the State agency, with such annual adjustments as may be necessary. Each such plan shall be based upon a uniform format for area plans within the State prepared in accordance with section 307(a)(1). Each such plan shall—

(1) provide, through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance, or construction of multipurpose senior centers, within the planning and service area covered by the plan, including determining the extent of need for supportive services, nutrition services, and multipurpose senior centers in such area (taking into consideration, among other things, the number of older individuals with low incomes residing in such area, the number of older individuals who have greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals who have greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals at risk for institutional placement residing in such area, and the number of older individuals who are Indians residing in such area, and the efforts of voluntary organizations in the community, evaluating the effectiveness of the use of resources in meeting such need, and entering into agreements with providers of supportive services, nutrition services, or multipurpose senior centers in such area, for the provision of such services or centers to meet such need;

(2) provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and s ervice area will be expended for the delivery of each of the following categories of services —

(A) services associated with access to services (transportation, health services (including mental health services) outreach, information and assistance, (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);

(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance; and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded;

(3) (A) designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers (including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point; and

(B) specify, in grants, contracts, and agreements implementing the plan, the identity of each focal point so designated;

(4)(A)(i) (I) provide assurances that the area agency on aging will —

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low -income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of sub-clause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low -income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low -income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas i n accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with

limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(I) identify the number of low-income minority older individuals in the planning and service area;

(II) describe the methods used to satisfy the service needs of such minority older individuals; and

(III) provide information on the extent to which the area agency on aging met the objectives described in

clause (i);

(B) provide assurances that the area agency on aging will use outreach efforts that will—

(i) identify individuals eligible for assistance under this Act, with special emphasis on—

(I) older individuals residing in rural areas;

(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(IV) older individuals with severe disabilities;

(V) older individuals with limited English proficiency;

(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(VII) older individuals at risk for institutional placement; and

(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance; and

(C) contain an assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas;

(5) provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement with agencies that develop or provide services for individuals with disabilities;

(6) provide that the area agency on aging will—

(A) take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;

(B) serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older individuals;

(C)(i) where possible, enter into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children, and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families;

(ii) if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that-

(I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42 U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or

(II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs; and that meet the requirements under section 676B of the Community Services Block Grant Act; and

(iii) make use of trained volunteers in providing direct services delivered to older individuals and individuals with disabilities needing such services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service), in community service settings;

(D) establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;

(E) establish effective and efficient procedures for coordination of —

(i) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and

(ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;

(F) in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging

with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

(G) if there is a significant population of older individuals who are Indians in the planning and service area of the area agency on aging, the area agency on aging shall conduct outreach activities to identify such individuals in such area and shall inform such individuals of the availability of assistance under this Act;

(7) provide that the area agency on aging shall, consistent with this section, facilitate the area-wide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by —

(A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care;

(B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better—

(i) respond to the needs and preferences of older individuals and family caregivers;

(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and

(iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;

(C) implementing, through the agency or service providers, evidence-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and

(D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information relating to —

(i) the need to plan in advance for long-term care; and

(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources;

(8) provide that case management services provided under this title through the area agency on aging will—

(A) not duplicate case management services provided through other Federal and State programs;

(B) be coordinated with services described in subparagraph (A); and

(C) be provided by a public agency or a nonprofit private agency that —

(i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging;

(ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;

(iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or

(iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);

(9) provide assurances that the area agency on aging, in carrying out the State Long -Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title;

(10) provide a grievance procedure for older individuals who are dissatisfied with or denied services under this title;

(11) provide information and assurances concerning services to older indiv iduals who are Native Americans (referred to in this paragraph as ‘‘older Native Americans’’), including—

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assuranc e that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are avai lable to older individuals within the planning and service area, to older Native Americans; and

(12) provide that the area agency on aging will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b) within the planning and service area.

(13) provide assurances that the area agency on aging will —

(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;

(B) disclose to the Assistant Secretary and the State agency —

(i) the identity of each nongovernmental entity with whi ch such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship;

(C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such contract or such relationship;

(D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such contract or such relationship; and

(E) on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals;

(14) provide assurances that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title;

(15) provide assurances that funds received under this title will be used —

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(16) provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care; and

(17) include information detailing how the area agency on aging will coordinate activities, and develop long-range emergency preparedness plans, with local and State emergency response agencies, relief organizations, local and State governments, and any other institutions that have responsibility for disaster relief service delivery.

(b)(1) An area agency on aging may include in the area plan an assessment of how prepared the area agency on aging and service providers in the planning and service area are for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(2) Such assessment may include —

(A) the projected change in the number of older individuals in the planning and service area;

(B) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(C) an analysis of how the programs, policies, and services provided by such area agency can be improved, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the planning and service area; and

(D) an analysis of how the change in the number of individuals age 85 and older in the planning and service area is expected to affect the need for supportive services.

(3) An area agency on aging, in cooperation with government officials, State agencies, tribal organizations, or local entities, may make recommendations to government officials in the planning and service area and the State, on actions determined by the area agency to build the capacity in the planning and service

area to meet the needs of older individuals for—

(A) health and human services;

(B) land use;

(C) housing;

(D) transportation;

(E) public safety;

(F) workforce and economic development;

(G) recreation;

(H) education;

(I) civic engagement;

(J) emergency preparedness; and

(K) any other service as determined by such agency.

(c) Each State, in approving area agency on aging plans under this section, shall waive the requirement described in paragraph (2) of subsection (a) for any category of services described in such paragraph if the area agency on aging demonstrates to the State agency that services being furnished for such category in the area are sufficient to meet the need for such services in such area and had conducted a timely public hearing upon request.

(d) (1) Subject to regulations prescribed by the Assistant Secretary, an area agency on aging designated under section 305(a)(2)(A) or, in areas of a State where no such agency has been designated, the State agency, may enter into agreement with agencies administering programs under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act for the purpose of developing and implementing plans for meeting the common need for transportation services of individuals receiving benefits under such Acts and older individuals participating in programs authorized by this title.

(2) In accordance with an agreement entered into under paragraph (1), funds appropriated under this title may be used to purchase transportation services for older individuals and may be pooled with funds made available for the provision of transportation services under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act.

(e) An area agency on aging may not require any provider of legal assistance under this title to reveal any information that is protected by the attorney-client privilege.

(f) (1) If the head of a State agency finds that an area agency on aging has failed to comply with Federal or State laws, including the area plan requirements of this section, regulations, or policies, the State may withhold a portion of the funds to the area agency on aging available under this title.

(2)(A) The head of a State agency shall not make a final determination withhold ing funds under paragraph (1) without first affording the area agency on aging due process in accordance with procedures established by the State agency.

(B) At a minimum, such procedures shall include procedures for —

(i) providing notice of an action to w ithhold funds;

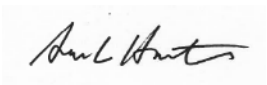
(ii) providing documentation of the need for such action; and

(iii) at the request of the area agency on aging, conducting a public hearing concerning the action.

(3) (A) If a State agency withholds the funds, the State agency may use the f unds withheld to directly administer programs under this title in the planning and service area served by the area agency on aging for a period not to exceed 180 days, except as provided in subparagraph (B).

(B) If the State agency determines that the area agency on aging has not taken corrective action, or if the State agency does not approve the corrective action, during the 180-day period described in subparagraph (A), the State agency may extend the period for not more than 90 days.

The Secretary of the Executive Office of Elder Affairs of the Commonwealth of Massachusetts, hereby commits the State Unit on Aging to performing the preceding listed assurances and required activities and procedures.



August 21, 2009

Ann L. Hartstein, Secretary
Executive Office of Elder Affairs
Commonwealth of Massachusetts

Date

Appendix D: 2009 Statewide Needs Assessment Report

2009 Statewide Needs Assessment Report
For the 2010-2013 State Plan on Aging

Commonwealth of Massachusetts
Executive Office of Elder Affairs

Ann L. Hartstein, Secretary

July 2009

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Throughout the project, directors, planners and staff from the Area Agencies on Aging (AAAs), Aging Services Access Points (ASAPs), Councils on Aging (COAs), and Professional Associations (e.g., Massachusetts Home Care Association, Massachusetts Association of Older Americans) provided invaluable suggestions and assistance to gather relevant and accurate information.

We are most grateful to the planners from the following AAAs:

Baypath Elder Services, Inc.
Boston Commission on Affairs of the Elderly
Bristol Elder Services
Central Mass Agency on Aging, Inc.
Chelsea/Revere/Winthrop Home Care Center, Inc.
Coastline Elderly Services, Inc.
Elder Services of Berkshire County, Inc.
Elder Services of Cape Cod and the Islands, Inc.
Elder Services of Merrimack Valley, Inc.
Franklin County Home Care Corporation.
Greater Lynn Senior Services, Inc.
Greater Springfield Senior Services, Inc.
HESSCO Elder Services, Inc.
Highland Valley Elder Services, Inc.
Minuteman Senior Services, Inc.
Mystic Valley Elder Services, Inc.
North Shore Elder Services, Inc.
Old Colony Planning Council
SeniorCare, Inc.
Somerville/Cambridge Elder Services, Inc.
South Shore Elder Services, Inc.
Springwell, Inc.
WestMass ElderCare, Inc.

We also appreciate the assistance of Sue Mandella who created the web link at UMass 800AgeInfo.com that enabled the general public to complete the questionnaire online. In addition, our appreciation is extended to Martina Jackson, Communications/Outreach/Press, and Sue Thomson, Chief of Staff, both of whom facilitated the posting of the Providers' Questionnaire on EOEA's home webpage.

Contents

Executive Summary

A three-level data collection approach was used for the 2009 Statewide Needs Assessment Study. The primary level is information from need assessment events conducted by the AAAs. The secondary level consists of information from providers who render direct care services and from the Commonwealth's municipalities. The tertiary level is information garnered from th e general public. The information gathered from these four sources address EOHHS' and EOEA's initiatives as well as those identified by AoA.

Some 6,225 elders and their stakeholders participated in 206 single -and multiple-day need assessment events conduc ted by the AAAs from October 2007 through December 2008. From among 279 providers who employ direct care workers, 36% (n=87) completed the questionnaire administered from 2008 August 15th through November 15th. From among 249 municipalities in the commonwealth, 64% (n=224) of the communities completed a questionnaire administered from 2008 September 1st through November 15th. Finally, a questionnaire was posted on the 800AgeInfo website from 2008 August 15th through December 15th to learn about elder needs and concerns from the general public. Although some 550 respondents viewed the questionnaire, information are based on 521 participants. The participants from events held by the AAAs and the statewide questionnaire deviates from the Commonwealth's socio -demographic distribution; however, collectively the voiced needs and concerns are very similar.

The three priority areas of concerns are Health Care and Financial Security (tied ranking) and Transportation followed by Family Caregiving/Support Networks, Housing/Home Ownership, and Maintaining Independence/Dignity. Health care concerns include assistance with medication/ prescription costs, co-payments, health insurance plans that provide better medication and sensory (dental and vision) coverage, medication management, and assistance before, during and after medical appointments. Concerns under financial security include increased cost of living expenses or insufficient income to cover medical bills and prescription drugs, cover home/housing related expenses, afford dental care, stay connected with family/friends, and afford groceries.

Repeatedly voiced by the respondents is access to reliable, flexible and affordable transportation services. The same for more affordable housing and assistance with home own erships (i.e., mortgage/rent payments, property taxes/fees, fuel assistance, utility expenses, home repairs and maintenance expenses) and home modifications expenses. Consumer-directed care is at the forefront and maintaining independence/dignity remains a core service requirement to support elders to remain in their homes. Both municipalities and respondents voice need for more home and health care workers in order to support elders to remain in their homes . While providers of direct care workers will likely continue their standard recruitment and retention practices, workforce development challenges facing this industry include providing competitive wages, establishing career-ladder opportunities, and reducing turnover rates .

Statewide respondents under 60 years of age identified caregiver support as their primary area of concern, likely due to more than half serving as informal caregivers to one or more persons. They also seek access to mental health services including screenings and support programs. Fur ther, they

recommend the EOEA help prepare residents to plan for their medical and non-medical long-term care needs.
Call demands for EMS have been increasing in more than half the communities (n=103), and steps have been taken to address the increased trend in 35% of these communities. A registry or record of people who require additional assistance is maintained in more than half of the communities. The COAs and senior centers take part in the community's disaster preparedness planning. Some maintain and update a local registry that identifies fewer than 25 to over 900 persons who require assistance during a natural or man-made disaster. More than half of the communities offer evidenced-based prevention programs, with at least one specifically focused upon falls prevention.

About half the communities promote healthy aging through physical activities that focus on muscular endurance and balance-breathing/posture. Aerobics followed by dancing, yoga, and meditation, tai chi and walking are the most popular types of physical activities engaged in by elders. In addition, in 40% of the communities that offer physical activities programs, elders have access to fitness equipment to help them develop or maintain muscular strength and endurance. Fitness equipment most in use by elders includes weights followed by resistance bands, treadmills, upright and/or recumbent bicycles and elliptical machines. More health screening and immunizations programs, falls prevention programs, and leisure and recreational programs are sought by both residents and communities.

While communities recommend EOEA to expand the capacity of protective services (abuse, fraud, exploitation, neglect and self-neglect) for elders, participants from AAA events also indicated a need for well-maintained, unobstructed sidewalks with visible curb cuts, adequate street lighting for pedestrian safety, and better maintained public housing facilities for their safety and security. From among vulnerable target populations, the scope and breadth of elder services needs to be made accessible and available, especially for persons whose first language is not English and LGBT adults.

Coordination and management of services is paramount for elders and their caregivers as the voiced concerns/issues are interconnected or linked with multiple areas of concerns. Although the ranking of priority issues may vary from the different venues of data gathering, primary issues are health care, financial security, transportation, family/caregiving/support networks, housing/ home ownership, and maintaining independence/dignity. Secondary issues are education/learning, food and nutrition, leisure and recreation activities, long-term care, legal services, mental health services, and safety/security. Tertiary issues are career/employment, spirituality, and volunteer opportunities/civic engagement.

The major recommended service supports for EOEA to undertake are:

- Improve access/increase public and paratransit transportation options.
- Expand affordable elder housing capacity and support options.
- Increase home and health care workforce.
- Promote healthy aging through physical activities, fitness and recreation including injury/falls prevention programs.
- Establish a single, coordinated system of information and access for all persons seeking long-term supports.

- Invest in outreach to targeted populations to raise their awareness of available services and supports.
- Expand capacity of protective services (abuse, fraud, exploitation, neglect and self -neglect) for elders.
- Encourage residents to plan for medical and non-medical long-term care needs.
- Improve access to mental health services including screenings and support programs.
- Promote preventive health including screenings and immunizations

I. 2009 Needs Assessment Study Design

In preparing the four-year State Plan on Aging for the Older Americans Act, the Executive Office of Elder Affairs (EOEA) has historically gathered information about elders' needs through a statewide needs assessment questionnaire. Since 1993, a 4 -page survey, developed in collaboration with the 23 Area Agencies on Aging (AAAs), has been mailed to a random sample of approximately 11,000 elders across the Commonwealth. Completed surveys were returned to EOEA with findings summarized and disseminated to the AAAs for incorporation in their respective local plans.

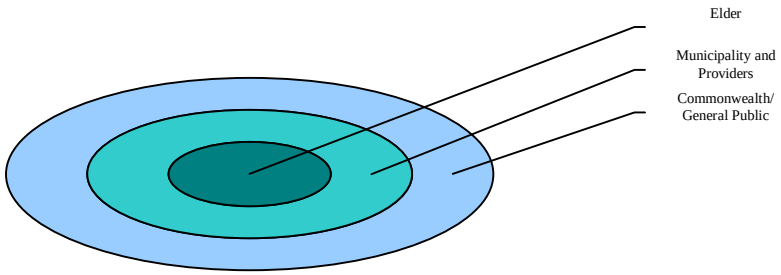
For the 2009 Needs Assessment study, instead of inquiring about 31 specific service needs, service needs were classified under 16 headings (areas of concerns) and incorporated concepts from "livable communities for all ages" and service areas listed in the Older Americans Act. The perspective for the areas is that all are interconnected during one's life span and no area more critical than another. However, since breakdowns occur along a person's life span (e.g., job loss, illness) certain areas surface for attention and assistance.

The 16 areas of concerns are classified under the following headings:

- Career/employment
- Education/learning
- Family/caregiver/support networks
- Financial security (money/finances)
- Food and nutrition
- Health care
- Housing/home ownership
- Legal assistance
- Leisure, recreation and physical activities
- Long-term care
- Maintain independence/dignity
- Mental health
- Transportation/personal mobility
- Safety and Security (personal/public)
- Spirituality
- Volunteer opportunities/civic engagement

Methodology

For the 2009 Needs Assessment, a three-level participation framework was used instead of a single questionnaire. As shown in Figure 1, elders reside in a community (municipality) which coexists in the larger community (Commonwealth). A three-level participation framework was used to gather information from elders and their support networks, communities and selected providers, and the general public.



Primary Level: Elders and their Support Networks

The AAAs conduct their own local needs assessment activities to prepare their local area plans. Since their findings would typically not be available until after the state plan is developed or submitted to AoA, AAA planners were asked to submit their findings to EOEA after each needs assessment event using a single sheet reporting form. (The parameters for the decentralized data gathering activities and classification of needs under 16 areas of concerns were provided.) In this manner, the findings from the AAAs need assessment events could be incorporated with the statewide findings.

Secondary Level: Communities and Providers

We sought to learn from direct care worker providers what needs or concerns they have in providing services to elders and their families. The information would assist EOEA to ascertain what, if any, aspects of service delivery may need to be modified to ensure standards of care are uniformly delivered to the consumers. The Providers' Questionnaire would be administered by mail with respondents having the option to respond electronically via the web or email, or completing the hard copy and returning it by fax or mail.

The focus of the Municipal Questionnaire was to gain a snapshot of the community's preparedness for both current and imminent aging of residents. The questionnaire was composed of three parts.

Part A focused on what three services the municipalities currently provided, what five service areas they would focus on between now and 2013, and which from among 15 listed items they would recommend EOEA to focus on between now and 2013.

Part B is composed of four sections and labeled Safety and Security. Items generated were developed around two AoA Strategic Action Plan 2007-2012 Program Goals (specifically goals 2 and 3) and seven HHS Strategic Plan Objectives (see Chart 1) as well as EOHHS' goals (specifically, Wellness and Quality of Health Care, and Safe Communities), and EOEA's initiatives pertaining to physical activities and falls prevention. With emphasis for elders to remain in the community and

falls a leading cause of unintentional injuries to elders , Section 1 sought to ascertain what trends were occurring in call demands for emergency medical services (EMS) in the communities. Section 2 sought to identify if the community maintained a registry or record of people who required additional assistance should a natural or man-made disaster or threat occurred. Section 3 sought to identify what types of evidenced-based prevention programs, especially falls prevention programs, were offered for elders in the community. Finally, Section 4 requested information about the types of physical activity programs/classes offered to elders and fitness equipment available to elders in the communities.

Part C was designed to learn about the community's preparedness for the aging population in 20 areas. Items were generated from 'livable communities' and 'aging in place' literature. The directors of the Councils on Aging (COA) and Senior Centers would be asked to complete the questionnaire, and administered electronically via the web and email as well as mailing a paper version to directors without an email addresses. Respondents would have the option of submitting their responses via the web, email, fax or mail.

Tertiary Level: General Public

Finally, a 4-page questionnaire has historically been mailed to a random sample of elders only. However, many under age 60 provide care to elders and their perspectives were also regarded essential. As a result, we proposed to post a web survey to ascertain the most prevalent concerns and issues facing elders and to obtain recommendations for their communities and EOEA to focus on between now and 2013.

The context of the 2009 Needs Assessment Study is desig ned around AoA's Strategic Action Plan 2007-2012 as shown in chart 1. Gathering information directly from elders about their concerns and needs was decentralized through the AAAs in contrast to the centralized system used in past studies. The questionnaires used to garner information from the providers, communities, and general public were developed in collaboration with the AAAs, COAs and E OEAD staff and administered centrally from EOEA .

The findings from each of the three levels of data gathering are p resented in sections II through V. For each data gathering activity, a description of the respondents is provided followed by the results in the sequence of the items in the questionnaire. The summary report from the AAA planners and the three questionnaires are included in Appendix A. Secondary tables and charts from each data gathering initiative are in appendices B through E , that is, AAA Planners' in appendix B, Providers' Questionnaire in appendix C, Municipal Questionnaire in appendix D, and Survey of Elder Service Needs (general public) in appendix E.

In Section VI, Discussion, some comparison data are presented for selected items. Finally, Section VII highlights the major findings from the four data sources.

Chart 1

HHS Strategic Plan FY 2007-20012 Goals & Objectives	AoA Strategic Action Plan 2007-2012 Program Goals				
	Objective	Goal 1: Empower elder people and to families to make informed decisions about, and be able to easily access, existing home and community-based options.	Goal 2: Enable seniors to remain in their own homes with high quality of life for as long as possible through the provisions of home and community-based services, including supports for family caregivers.	Goal 3: Empower older people to stay active and healthy through OAA services and the new prevention benefits under Medicare.	Goal 4: Ensure the rights of older people and prevent their abuse, neglect and exploitation.
Obj. 1.1	Broaden health insurance and long-term care coverage.				
Obj. 1.2	Increase health care service availability and accessibility.				
Obj. 1.3	Improve health care quality, safety, cost, and value.				
Obj. 1.4	Recruit, develop, and retain a competent health care workforce.		Providers' Questionnaire		
Obj. 2.1	Prevent the spread of infectious diseases.				
Obj. 2.2	Protect the public against injuries and environmental threats.		Municipal Questionnaire	Municipal Questionnaire	
Obj. 2.3	Promote and encourage preventive health care, including mental health, lifelong health behaviors and recovery		Municipal Questionnaire	Municipal Questionnaire Statewide Questionnaire	
Obj. 2.4	Prepare for and respond to natural and man-made disasters.		Municipal Questionnaire		
Obj. 3.1	Promote the economic independence and social well-being of individuals and families across the lifespan.		AAAs Planners Report Municipal Questionnaire, Part A Statewide Questionnaire	AAAs Planners Report Municipal Questionnaire, Part A Statewide Questionnaire	
Obj. 3.3	Encourage the development of strong, healthy and supportive communities.		AAAs Planners Report Municipal Questionnaire, Part C	AAAs Planners Report Municipal Questionnaire, Part C	
Obj. 3.4	Address the needs, strengths and abilities of vulnerable populations.		AAAs Planners Report Municipal Questionnaire, Parts A & B Statewide Questionnaire	AAAs Planners Report Municipal Questionnaire, Parts A & B Statewide Questionnaire	
Obj. 4.4	Communicate and transfer research results into clinical, public health, and human service practice.				

Key: HHS Strategic Plan

- Goal 1: Health Care
- Goal 2: Public Health Promotion and Protection, Disease Prevention and Emergency Preparedness
- Goal 3: Human Services
- Goal 4: Scientific Research and Development

II. AAA Planners' Needs Assessment Reports

With each AAA conducting data gathering activities to prepare for their local plans, each AAA planner was asked to complete a Needs Assessment Reporting Form (see appendix A) for each event held from March 2008 through November 2008. However, be cause some AAAs' data gathering initiatives began earlier and ended later, reported activities cover the period from October 2007 through December 2008 (15 months).

For each event, requested information included start and end time of event, total partici pants, socio-demographic characteristics, if available, method of gathering needs of elders, and identification of the top three areas of concerns and top three issues. A list of 16 areas of concerns and list of methodologies were included with the form (s ee appendix A). The summaries are a partial record of AAAs activities and do not include secondary data analyses or other internal management or program performance/outcome findings undertaken by the AAAs.

A. Description of AAAs' Need Assessment Events

The findings include reports from 22 of 23 AAAs due to a planner on long-term leave. Two-hundred-four reports were received from individual AAAs, and two reports from events sponsored by a joint collaboration of five AAAs. Eighty percent (n=165) of the events were held within a single day and 20% (n=41) across multiple weeks.

For single day events, participants ranged from 3 to 322 p eople with a median of 11 persons per event. Events were held from a minimum of ten minutes to a maximum of 6 hours. The typical event was 90 minutes in length (33%), followed by a 60 -minute (23%) and a 120-minute (11%) event. Collectively, two-thirds of the single day events were held from one to two hours. For multiple day events, data gathering spanned from one week to an entire year with the median four weeks in duration.

Among the 206 events, 88% (n=181) were held with consumers and stakeholders, and 12% (n=25) with stakeholders only. Among events with consumers, 3 of every 4 were held in group settings (55% in small group setting or under 15 people; 45% in large group setting or 15 or more people). Small group events included focus groups, coffee hours, listening sessions, and community meetings. Elders were also surveyed at congregate meal sites and in support group sessions. Large group events included the same headers used in the small group setting and were often integrated with other physical activity sessions, educational sessions, screening clinics, and at special events such as Health Fairs, Senior Expos and luncheons.

Twenty percent of the events were self -administered questionnaires. The questionnaires were administered via mail, at congregate meal sites, with home delivered meals, in exercise classes or at congregate meal sites, left at various sites, and electronically via the internet. Four percent were one-on-one conversations via telephone, door-to-door, and face-to-face interviews. Finally, 1% was conducted by convening a task force.

Twenty-five events (12%) were specifically held with stakeholders, t hat is, COAs, AAA, ASAP, advocates and experts. Sessions were also held with elder advisory groups and program specialist s (e.g., nutrition and housing). Across the 38 reports, the number of advocates ranged from one to 63 with three the median number of advocates in attendance.

In terms of the socio-demographic characteristics of the respondents , minorities, persons of Spanish/Latino heritage, linguistic minority speakers, and persons with economic, social or both needs participated in the events. The su mmaries in Table AAA_1 reflect the vulnerable population characteristics that were known to the person who completed each report or had conducted the event. By race, Blacks were included in 38% of the events, Native American/Pacific Islanders in 6%, and Asians in 16%. Approximately 1 of every 5 events included persons of Spanish/Latino heritage and linguistic minorities (primarily Spanish, Portuguese, Russian and Chinese). Almost 70% of the events included low income elders; 9% of the events included low i ncome minority elders.

Elders identified as vulnerable were in attendance at the events. Leading the way were frail elders who were present in 40% of the events. Following closely in attendance/participation were isolated elders (36%), caregivers (33%), elders with disabilities (30%), elders requiring nutrition/meal assistance (29%), persons with Alzheimer's disease or other related disorders (24%), persons with cognitive disorders (22%), and rural elders (17%). Others (8%) included elders with low -vision or mental illness, abused/neglected/exploited elders, LGBT adults, boomers, grandparents, and veterans.

B. Priority Service Need Areas

The planners were asked to identify the top three priority areas voiced in each event and to classify the needs under 16 areas. Among the 590 cited across the 206 events, the top three priority areas which collectively accounts for nearly half (49%) of elders' voiced needs are (Table AAA_2):

- Health Care and Transportation (tied)
- Financial Security

Housing/Home Ownership, Maintaining Independence/Dignity, and Family/Caregiving/Support Networks follow and accounts for another 27% of elders' needs. These six areas collectively account for more than 75% of elders' voiced needs.

C. Major Issues/Concerns Voiced for the Top Six Priority Areas

The AAA planners also identified issues/concerns under the 16 areas (Table AAA_3), and they closely correspond with the ranked priority areas. The major issues/concerns voiced by participants from the needs assessment events are pre sented for the six priority areas. The expressed issues/concerns (e.g., cost, access, service quality, reliability or frequency) for the 16 areas are presented in Table AAA_3a, appendix B.

Table AAA_1
Vulnerable Population (181 Reports with Consumers Only)

Vulnerable Population	Single Day Event(N=145)		Multiple Day Event (n=36)		Total (n=181)	
	N	%	N	%	N	%
Number of participants	3,542	60.9	2,271	39.1	5,813	100.0
Race						
White	90	62.1	16	44.4	106	58.6
Black	49	33.8	15	41.7	64	35.4
Native American/Pacific Islander	5	3.4	5	13.9	10	5.5
Asian	21	14.5	7	19.4	28	15.5
Multiracial/Other	35	24.1	7	19.4	42	23.2
Spanish/Latino	22	15.2	12	34.0	34	18.8
Linguistic Minority (languages identified)	28	19.3	10	27.8	38	21.0
Chinese -- Mandarin & Cantonese	4		1		5	
Haitian Creole	4				4	
Hindi	1				1	
Italian			2		2	
Khmer	2		1		3	
Portuguese	5		3		8	
Russian	4		3		7	
Spanish	12		1		13	
Economic Need						
Low Income	44	30.3	7	19.4	51	28.2
Low income Minority	16	11.0	1	2.8	17	9.4
Low income non-Minority	44	30.3	13	36.1	57	31.5
Social Need						
Frail elders	43	29.7	17	47.2	72	39.8
Isolated elders	34	23.4	18	50.0	65	35.9
Caregiver Support for Elders	36	24.8	9	25.0	60	33.1
Disabilities	36	24.8	8	22.2	54	29.8
Nutrition-meals	29	20.0	15	41.7	53	29.3
Alzheimer's disease and other related disorders	23	15.9	8	22.2	43	23.8
Cognitive Impairments	22	15.2	8	22.2	39	21.5
Rural elders	16	11.0	5	13.9	30	16.6
Other	13	9.0	2	5.6	15	8.3
Boomer	1				1	
Abused, neglected, exploited	1				1	
Mental illness	1		1		2	
LGBT	7				7	
Low vision	2				2	
Veterans			1		1	
Grandparents	1				1	

Table AAA_2
Priority Areas Voiced at 206 Events Sponsored by the AAAs

Rank	Areas	Priority (n=590)		
		N	%	Cum %
1	Health Care	103	17.5	34.9
1	Transportation	103	17.5	
3	Financial security	83	14.1	49.0
4	Housing	71	12.0	61.0
5	Maintain independence/Dignity	46	7.8	68.8
6	Family/Caregiving/Support networks	40	6.8	75.6
7	Food and Nutrition	30	5.1	80.7
8	Safety/Security	27	4.6	85.2
9	Long-term care	23	3.9	89.1
10	Leisure/Recreation	20	3.4	92.5
11	Mental Health	19	3.2	95.7
12	Education/Learning	14	2.4	98.1
13	Legal assistance	6	1.0	99.1
14	Volunteer/Civic engagement	4	0.7	99.8
15	Career/Employment	1	0.2	100.0
16	Spirituality	0	0.0	100.0

Table AAA_3
Issues Voiced at 206 Events Sponsored by the AAAs

Rank	Areas	Issues (n=602)		
		N	%	Cum %
1	Health Care	101	16.8	16.8
2	Transportation	97	16.1	32.9
3	Financial Security	82	13.6	46.5
4	Housing	75	12.5	59.0
5	Maintain independence/Dignity	52	8.6	67.6
6	Family/Caregiving/Support networks	46	7.6	75.2
7	Food and Nutrition	33	5.5	80.7
8	Long-term care	30	5.0	85.7
9	Safety/Security	26	4.3	90.0
10	Mental Health	21	3.5	93.5
11	Leisure/Recreation	19	3.2	96.7
12	Education/Learning	12	2.0	98.7
13	Legal assistance	5	0.8	99.5
14	Volunteer/Civic engagement	3	0.5	100.0
15	Career/Employment	0	0.0	100.0
15	Spirituality	0	0.0	100.0

Health Care (n= 102)

37% Cost of health care – need for more affordable medications/prescription drugs; unable to afford sensory services (primarily dental and vision).

38% Setting aside the issue of affordability,
- 17% need better health insurance plans – to cover assistive technologies such as wheelchairs, dental/vision/hearing care, prescription/drug benefits, and physicals and screenings.
- 12% need access to affordable dental care followed by vision and hearing.
- 9% need assistance with managing medications and learning about the side effects of taking single or multiple medications.

12% Concerns about their health or chronic health conditions (e.g., memory loss, managing chronic illness, loss of mobility from an injury or fall, onset of dementia or Alzheimer's d isease).

10% Need assistance before, during and after medical appointments (e.g., doctors are pressed for time that elders need to prepare their questions ahead of time, getting hold of doctors, coordinating their health service needs, help in "getting set tled" at home after an out patient procedure).

4% Other -- Medical supplies, assistive technology and health education.

Transportation Services (n=97)

68% Access to transportation services for medical appointments, basic errands, socialization or extr a curricular activities, and getting to congregate meal sites.

21% Better public transportation services (i.e., more reliable and frequent services, more personalized services [fewer stops], flexible hours, shorter notices when arranging for pick ups [ability to see a doctor sooner when a cancellation occurs], and door -to-door services).

10% Affordable transportation services (e.g., more taxi vouchers, chair vans and subsidized or discounted programs).

1% Assistance of another for medical appointments.

Financial Security (n=82)

63% Insufficient income for prescription drugs, home/housing related expenses (i.e., property taxes, rent/mortgage, utilities, home repairs/maintenance, and fuel), dental care, and medical bills and treatments.

17% Concern about increase in the cost of living (how to make ends meet).

12% Inability to stay connected with family (e.g., visit family members).

7% Other -- mental health services, tax preparation, privatization of social security, and inability to participate in leisure activities.

Housing/Home Ownership (n=75)

37% Need affordable housing, primarily more low income/subsidized housing for seniors, rent control, housing for people with mental illness and for lesbian, gays, bisexual and transsexual (LGBT) elders.

31% Assistance with home repairs as well as for home modifications and maintenance items.

24% Assistance with housing expenses -- primarily fuel assistance (gas/oil), local taxes and fees, and utilities.
8% Other -- tenant issues, and parking and clearing snow o ff their cars.

Maintain Independence/Dignity: (n=52)

42% Current/potential isolation, i.e., seniors are alone, have no family or friends, or inability to get around.
21% Need information about available services as well as help applying for services (e.g ., SSI, SNAP).
14% Need access and services made available to those who do not speak English (language barrier).
14% Need assistance with life transitions (e.g., loss of role, identity).
10% Better access and services available to elders from different cultures or sexual orientation.

Family/Caregiving/Support Networks (n=46)

47% Need more or able to use Caregiver Support Program services.
23% Assistance to resolve barriers informal caregivers face (e.g., limited support by family members, need financial support, direct service help for caregivers).
19% Need to support informal caregivers for their services (e.g., provide medical escort role, interpreter role, manager/coordinator of services for care recipient).
11% Need training for caregivers (e.g., stress reduction techniques, intergenerational programs).

III. Providers' Questionnaire

With emphasis on supporting elders to remain in the community, the Providers' Questionnaire (PQ) sought information about agency staffing patterns, trainings, and challenges facing the home care industry. A single sheet, two-sided questionnaire was developed to gather the information from service providers of the AAAs and ASAPs. For fiscal year 2008, 689 service providers were identified via the Senior Information Management System. Providers who likely offered Adult Day Health, Adult Foster Care, Chore, Companion, Dementia Day Care, Emergency Shelter, Home Health Aide, Homemaker, Personal Care, and Supportive Day Care were selected. Duplicate records as well as providers rendering services other than home care services were removed (e.g., laundry services, grocery delivery, transportation, consumer credit counseling, nursing home, landscape, rest homes, etc.) .

The PQ was mailed to 279 providers on August 15, 2008 with a return due date of October 5, 2008. The closing date was extended to November 15, 2008 to obtain a return rate of at least 30%. Respondents were asked to complete the survey via a web link or by returning the completed survey by fax or mail. Five respondents contacted the agency stating that they did not provide any of the ten services listed in the PQ. Thirty-six were returned unclaimed or undeliverable. One provider informed us of an agency oversight and a copy was mailed in November. A return rate of 36% (87/239) was attained; 55% (48) were mailed back, 25% (22) were faxed, and 20% (17) were completed via the web link.

Providers serving all eight service regions are represented (see Table PQ_1, appendix B). Most (78%) of the providers served a single service region and 22% multiple service regions. The Southeast Massachusetts region was inadvertently omitted in the survey. Three respondents, however, wrote in the service region. Excluding Southeast Massachusetts, 10-29 providers indicated serving a region.

Table PQ_2
Types and Number of Services (n=87)

Agency Services	N	Percent
Homemakers	54	62.1
Personal Care	53	60.9
Home Health Aide	44	50.6
Companion	37	42.5
Adult Day Health	24	27.6
Chore	21	24.1
Supportive Day Care	4	4.6
Adult Foster Care	3	3.4
Dementia Day Care	3	3.4
Emergency Shelter	0	0.0
Other (write in)	14	16.1

Number of Services	N	Percent
single	27	31.0
two	11	12.6
three	18	20.7
four	12	13.8
five	12	13.8
six	6	6.9
eight	1	1.1

The primary services offered by the providers are homemakers, personal care workers, home health aides, companions, adult day health services, and chore work. None provided emergency shelter; few provided supportive day care, adult foster care and dementia day care s ervices. Roughly, one-third of the providers rendered a single service, one -third 2 or 3 services, and remaining one -third 4 to 8 services.

A. Staffing Patterns

Three questions were directed to the respondents pertaining to staffing patterns: (a) the tot al number of employees including the number of full -and part-time direct care workers (DCWs), (b) the number of DCWs who left their agency in the last 12 months and their annual turn -over-rate, and (c) the length of employment for their newest and most sen ior DCW hired along with their average employment years.

Agency staffing patterns varied greatly. Based on 76 agencies, the total number of employees ranged from 1 to 450 people with a median of 46 (Table PQ_3). Full time DCWs ranged from none to 150 with the median of 8. Part time DCWs ranged from none to 420 with a median of 19. Both data on full -and part time DWS suggest that about half of the agencies employ eight or fewer full time DCWs and 19 or fewer part time DCWs. (The distribution of full and pa rt-time employees are presented in Charts PQ_1 and PQ_2, appendix B.)

Table PQ_3
Agency Staffing Patterns (n=76)

Descriptors		Employees		
		Total	Full time	Part time
Median		46	8	19
Range		449	150	420
Minimum		1	0	0
Maximum		450	150	420
Percentiles	20	12.4	2	2.4
	25	16.5	3	3.3
	40	35.8	6	12.0
	50	46.0	8	19.0
	60	59.8	9	30.2
	75	87.5	15	52.8
	80	109.2	20	64.8

With regard to full time or part time DCWs leaving the agency within the past 12 months, the number ranged from none to 189 (Table PQ_4). Reported turn -over-rates ranged from none to 130%. On average, six DCWs left their agency within a 12 -month period. The median turn-over-rate is 18%.

The term of employment for the newest DCW employee spanned from one month to 1 6 years with the median term of two months. At the other end of the spectrum, the most senior DCW was employed

from 1 year 3 months to 39 years with a median of 10 years. Reported average years of DCWs' employment ranged from three months to 17 years with 5 years the mid point (Table PQ_5).
The data suggest that DCWs are primarily part time employees. The typical home care agency is a medium size business employing 46 employees; the newest employee working two months and the most senior 10 years with an average of five years. The reported annual turn over rate among the agencies is 18% which suggest that about 1 of every 5 leave their positions annually.

Table PQ_4
Number of DCWs Left the Agency in the Last 12 Months (n=79)

		Number	Turn-over-rate Percent
Median		6	18
Range		189	130
Minimum		0	0
Maximum		189	130
Percentiles	20	1	2
	25	1	5
	40	3	11
	50	6	18
	60	10	22
	75	20	33
	80	24	41

Table PQ_5
Range of Employment Years (n=77)

Statistics		Employee (y.mm)		
		Newest	Most Senior	Average
Median		0.02	10.00	5.00
Range		15.11	37.09	16.09
Minimum		0.01	1.03	0.03
Maximum		16.00	39.00	17.00
Percentiles	20	0.01	6.00	2.05
	25	0.01	7.04	3.01
	40	0.01	9.04	4.01
	50	0.02	10.00	5.00
	60	0.05	12.10	6.00
	75	1.00	24.03	8.00
	80	1.09	25.00	9.05

B. Trainings

Excluding the mandatory annual home care aide trainings for DCWs (i.e., Universal Precautions, Elder Abuse and Neglect and the MA Patient Abuse S tatute, and Safety Policies including Patients' Rights, Back Safety, Home Safety and Emergency Procedures), respondents were asked to report on what other trainings were offered to DCWs, the primary topic of the training, number of attendees, length of training session, and if a certificate was issued to the attendee. Among those who responded to this section (n=82), 18% indicate no trainings were offered. Among the agencies that offered trainings, 4 of every 5 agencies offered two or three trainings annual ly with the majority (64%) holding three trainings (Table PQ_6).

Table PQ_6
Number of Trainings Offered (n=67)

Training Offered	Frequency	Percent	Cumulative
1	5	7.5	7.5
2	11	16.4	23.9
3	43	64.2	88.1
4	3	4.5	92.5
5	1	1.5	94.0
6	1	1.5	95.5
7	1	1.5	97.0
8	1	1.5	98.5
11	1	1.5	100.0

Among the 202 training titles/topics provided by the respondents, unfortunately, a few also appeared to have included titles/topics under the mandatory annual home care aide trainin g guideline. Among the training sessions offered, **health topics** (e.g., brain disorder, cardiovascular/stroke, respiratory disease, MS/MD, cancer, Parkinson's and communicable disease) and **safety** (i.e., CPR/first aid, fire safety and extinguish, accidents/f alls, disaster planning, driver safety) were primary (Table PQ_7). This is followed by **protecting patients and DCWs** (i.e., universal precautions, transmission -based precautions, blood borne pathogens standards, and patient safety) and **privacy and confidentiality** (e.g., HIPPA, sexual harassment, incident reporting, patient rights, boundaries). These four topic areas constituted 3 of every 5 trainings offered to DCWs.

Other topics included caring for elders (e.g., dealing with difficult clients, working wit h the disabled, visually impaired or dementia patients), review of administrative procedures (e.g., loss, theft and/or damage of client's property), mental health and substance abuse (e.g., depression, bipolar, suicide prevention), nutrition and food safet y (e.g., handling food safety, hydration, nutrition and the supermarket), geriatrics (e.g., aging process, life decisions for elders), personal care skills and diversity/awareness.

Nearly half of the training sessions were 1 hour or under in duration (47 %); about three quarters were 2 hours or under; 90% 4 or fewer hours (Table PQ_8). In more than half (54%) of the training

sessions, a certificate was issued to the attendees, while 42% indicated none and 5% did not specify whether a certificate was or was not issued.

Table PQ_7
Training Topics for Direct Care Workers

Topics	Frequency	Percent
Health topics	39	19.3
Safety (personal and home)	39	19.3
Protecting patients and DCWs	27	13.4
Privacy and confidentiality	21	10.4
Caring for elders	18	8.9
Other – Administrative procedures	13	6.4
Mental health/Substance abuse	10	5.0
Nutrition and food safety	10	5.0
Geriatrics	9	4.5
Personal care skills	9	4.5
Diversity/awareness	7	3.5

Table PQ_8
Number of Training Hours

Hour (h.mm)	Frequency	Percent
0.45	3	1.7
1.00	78	45.3
1.30	3	1.7
2.00	42	24.4
3.00	16	9.3
4.00	12	7.0
6.00	3	1.7
7.00	1	0.6
8.00	9	5.2
10.00	1	0.6
20.00	1	0.6
24.00	1	0.6
40.00	2	1.2
Total	172	100

C. Challenges

Inquiries were made about agencies' current pr actices in employing DCWs, and to ascertain the major challenge the agency or the industry is facing. Regarding current practices, r espondents were asked how likely, in the next five years, their agencies w ould focus on 15 listed practices. In addition for each item, to indicated if the agency is currently engaged in the practice (yes or no), and to indicate how likely they will undertake or will continue to engage in the activity using a five -point scale: very lively, likely, no change, unlikely, very unli kely (Table PQ_9, appendix B).

Between 69 and 73 respondents indicated their practices across the 15 items. All agencies reported that they currently ascertained clients' satisfaction with their DCWs (item O). While a few indicated a neutral stance of no change (7%), the overwhelming majority (93%) indicated that they will very likely or likely continue with this practice in the next five years.
Nearly all (92% - 99%) indicated that they currently engage in the following practices:

- increasing or providing competitive wage compensation (item A)
- reducing the number of on-the-job injuries (item C),
- recruiting qualified/skilled DCS (item E),
- reducing their DCWs' turn-over rate (item I), and
- improving supervision/management practices for DCWs (item N).

In the next five years, the agencies will likely or very likely continue with these practices and none will forego these practices.

Between 80% - 88% indicated that they currently engaged in the following practices:

- providing job security (item B)
- offering health insurance that DCWs can pick up and afford (item D)
- improving the job image of DCWs (item L), and
- including DCWs when reassessing client's care plans (item M).

Agencies currently rendering these practices indicated that they will very likely or likely continue with these standard practices in the next five years. For agencies that do not currently engage in these practices, most indicated no change in their standard practices for the next five years. For the few that do not currently offer health insurance (item D), 15% (2 of 13) indicated they will likely or very likely offer health insurance to their DCWs within the next five years. One-half (n=7) of the agencies that do not currently include DCWs when reassessing clients' care plan (item M) will likely or very likely include this practice in the next five years.

Nearly 80% (n=58) serve non-English speaking and culturally diverse populations. Among agencies that render this service, all indicated that they will very likely or likely continue with this current practice in the next five years. Among agencies that do not currently serve this segment of the population, a third indicated that they will likely serve non-English speaking and culturally diverse populations within the next five years.

Two-thirds (67%) of the agencies currently provide DCWs compensation for travel time/ transportation expenses (item H) and will continue with this practice in the next five years. A quarter (26%) of those who do not currently engage in this practice indicated that they will likely adopt this practice within the next five years.

More than 3 of every 5 agencies currently serve elders in rural or remote areas (item G), and will continue to serve this segment of the population. For agencies that do not currently serve elders in rural or remote areas, 7% (n=2) indicated that will likely serve this segment of the population in the next five years.

Nearly 60% currently ensure English language competency for DCWs whose first language is not English. Among these agencies, 95% (n=39) indicated that they will continue with their current practice and 5% (n=2) likely forgoing this practice in the future. Among the agencies that do not

currently engage in this practice, more than a third (34%) indicated a change will likely or very likely occur within the next five years.

Finally, slightly more than half (53%) of the agencies are currently developing a career advancement program for their DCWs. All but one will continue to attend to this practice. Among agencies that have not addressed a career advancement program for DCWs, 2 of every 5 (42%) indicated that they will likely address this within the next five years.

In summary, current practices in employing DCWs will likely continue as is, with modifications occurring from agencies that do not currently engage in certain practices. Specific changes most likely to occur in next five years are developing a career advancement program for DCWs (42%), ensuring English language competency for DCWs who first language is not English (34%), and offering health insurance that DCWs can pick up and afford (15%).

Major Challenges Facing Your Industry

Respondents were asked to list the major challenges facing their industry and to provide suggestion, if any, to help resolve the cited challenges. Cited challenges are summarized under policies, operational issues, DCWS' working conditions, and other (see Table PQ_10, appendix B).

First, regarding policies, respondents indicated attention on: a) need to have a level playing field regarding fair share of tax burden for their workers, b) costs incurred but not chargeable by the agency (e.g., clients who schedule services but are not at home to receive the DCWs), c) policies pertaining to 24/7 or 8-hour shifts, and d) unemployment compensation abuse. A recommendation regarding shift hours is to allow at a minimum, 10-hour shifts or even 12-hour shifts, especially for elders with dementia.

Second, respondents cited operational issues pertaining to DCWs, specifically, inability to provide competitive wages, need to reduce turn-over-rates, burn-out prevention, staff aging in place, absence of professionalism or lack of work ethics, recruitment, language barriers, and stabilization of working hours. Recommendations included increasing reimbursement rates, allowing competitive pay rates, career-ladder opportunities, including ethics in training programs, and establishing language competence prior to hiring.

Third, respondents cited the working conditions of DCWs that made recruitment or retention difficult. Specifically, they cited lack of interest in the field due to low wages, no reimbursements for mileage or travel expenses, and no health insurance offered or health insurance offered but not affordable for DCWs. Other challenges were clients' absence of respect toward DCWs, and under appreciation of employees in the human services field.

IV. Municipal Questionnaire

The Municipal Questionnaire (MQ) was administered from September 1, 2009 through an extended closing date of November 15, 2008. The web link to the MQ and an attached electronic version were emailed to Council on Aging (COA) directors serving 312 communities. The paper version was mailed to 33 COA directors, who served 37 communities, for whom no email addresses were a vailable.

The MQ was divided into three parts (see appendix A.) Part A, Service Priorities for Elders, sought to garner information about each municipal's current service priorities, initiatives they plan to focus on between now and 2013, and initiatives recommended for EOEA to focus on between now and 2013. Part B, Safety and Security, requested information about the community's Emergency Medical Services (EMS), Emergency Management Planning, and physical activities that promote fitness and falls prevention. Part C focused on the Aging Readiness of communities based on 'livable communities' and 'aging in place' literature. Respondents were asked to provide the status on an inventory of activities or practices in 20 areas; the items were generated by David Scott, AAA planner from the Greater Lynn Senior Services, Inc.

A total of 216 respondents representing 224 communities were received (Table MQ_1, appendix D), and represents a 64% return rate (224/349) f rom Massachusetts municipalities. Slightly more than half (52%, 112) were submitted via the web link while 25% (54) were mailed, 21% (46) emailed and 2% (4) faxed. About 9% of the questionnaires were partially completed.

The returned questionnaires represent responses from all 23 A AAs – a single to 60 municipalities constitute an AAA – as well as from communities with elders' under 500 in number through communities with 50,000 or more in number (Table MQ_2). About a quarter each of the survey respondents represent communities with elder populations under 1000, between 1,000 – 2,499 elders, between 2,500 – 4,999 elders, and 5,000 or more.

A. Service Priorities for Elders

1. Current Service Priorities

Sixteen service priority areas were listed in the MQ. Respondents were asked to indicate the top three areas their communities are currently focusing on to support elders. Statewide Transportation, Physical activity/Fitness/Falls prevention, and Food and Nutrition services (Table MQ_3) are indicated.

These priorities remain the same for 178 communities with elders numbering 500 through 9,999 elders. Transportation remains a top priority regardless of community size. In communities with less than 500 elder residents, Health care was identified as one of the ir top three current service priorities with Physical activity/Fitness/Falls prevention ranking fourth. In communities with 10,000 or more elders, Leisure and Recreational activities ranked in the top three with Food and Nutrition services ranked fourth.

Table MQ_2
Survey Respondents by AAA and Estimated Numbers of Elder Population

AAA	Estimated Elder Population in Respondent's Community										# Municipalities	# COAs in AAA
	Under 500*	500 – 999**	1,000 – 2,499***	2,500 – 4,999	5,000 – 7,499	7,500 – 9,999	10,000 – 24,999	25,000 – 49,999	50,000 and Over	# of Respondents		
BayPath		1	4	6			1			12	12	14
Berkshire‡	9	2	4	1			1			17	17	30
Boston									1	1	1	1
Bristol		1	2	2	1		1			7	7	15
Cape Cod & Islands		2	1	6	2	1	1			13	15	24
Central Mass	2	7	20	6	3			1		39	39	60
Coastline			2	2	1		1			6	6	8
CRW				1						1	1	3
Franklin‡	6	2	2	1						11	12	29
Greater Lynn				1			1			2	2	5
Greater Springfield		1	2	3	2					8	8	12
HESSCO		2	3	2	1					8	8	12
Highland	7	2	1	2	1					13	18	24
Merrimack	2	1	6	2	4	2	2			19	19	23
Minuteman		1	4	2	2	2	1			12	12	16
Mystic Valley				3	2	1	1			7	7	8
North Shore				1	1	2				4	4	5
Old Colony		1	3	7		1	2			14	14	23
SeniorCare			2	1						3	3	9
Somerville-Cambridge							1			1	1	2
South Shore			2	2	2	1	1			8	8	11
Springwell				1	2	2				5	5	8
WestMass			1	2		1	1			5	5	7
# of respondents	26	23	59	54	24	13	15	1	1	216	224	349
	12.0%	10.6%	27.3%	25.0%	11.1%	6.0%	6.9%	0.5%	0.5%	100.0%		

Asterisks indicate a questionnaire inclusive of multiple municipalities: * five additional municipalities; ** two additional municipalities; *** one additional municipality.
‡ Council on Aging (COA) does not exist for a community within the AAA.

2. Service Delivery Initiatives

Respondents were asked to indicate up to five from among 15 listed initiatives that their communities would focus on between now and 2013. Among 209 respondents (217 communities), 97% (n=202) indicated up to five and 3% (n=7) indicated more than 5 initiatives.

Regardless of the number of elders in a community, the top five service areas are (Table MQ_4):

1. Promote healthy aging through physical activity/fitness/falls prevention,
2. Promote preventative health care, screenings and immunizations,
3. Promote social connections and volunteer/civic engagement in the community,
4. Promote leisure and recreational activities, and
5. Promote public and paratransit transportation options.

For communities with less than a 1,000 elders and with 5,000+ elders, two additional initiatives were tied for the fifth priority area. Both community sizes indicated to "Help prepare residents for its aging population." However, communities under 1,000 indicated to "Improve our emergency response capacity for home and adult disabled residents," while communities with 5,000+ elders indicated to "Re-examine the role of senior centers in the community."

With regard to recommendations of up to five initiatives for EOEA to focus on between now and 2013 (Table MQ_5), 98% (n=202) indicated up to five initiatives while 2% (n=5) indicated more than five. Overall, the top five priority initiatives recommended for EOEA to focus on are:

1. Improve access/increase public and paratransit transportation options,
2. Promote healthy aging through physical activities/fitness/falls prevention,
3. Expand affordable elder housing capacity and support options,
4. Increase home and health care workforce, and (tied)
5. Invest in outreach to targeted populations to raise their awareness of available services and supports.
5. Expand capacity of protective services (abuse, fraud, exploitation, neglect and self-neglect) for elders.

There is a slight difference in recommended priorities for small communities (under 1,000 elders) and large communities (5,000+ elders). For small communities, promoting preventative health including screening and immunizations ranks among the top five, while expanding the capacity of protective services and investing in outreach to targeted population are secondary. For large communities, improving access to mental health services including screenings and support programs is ranked among the top five while expanding affordable elder housing and increasing home and health care workforces are secondary.

Table MQ_3
Current Service Priorities

Item #	Area	Community Size of Elder Residents															
		Under 500[1]		500-999[2]		1,000-2,499[3]		2,500-4,999		5,000-7,499		7,500+		10,000+		TOTAL	
		n=26		n=23		n=59		n=54		n=24		n=13		n=17		n=216	
15	Transportation/personal mobility	**13**	**50%**	**16**	**69.6%**	**41**	**69.5%**	**40**	**74.1%**	**17**	**70.8%**	**7**	**53.8%**	**9**	**52.9%**	**143**	**66.2%**
12	Physical activity/fitness/falls prevention	10	38%	**12**	**52.2%**	**29**	**49.2%**	**29**	**53.7%**	**13**	**54.2%**	**9**	**69.2%**	**9**	**52.9%**	**111**	**51.4%**
5	Food and nutrition	**11**	**42%**	**12**	**52.2%**	**36**	**61.0%**	**24**	**44.4%**	**13**	**54.2%**	**7**	**53.8%**	6	35.3%	**109**	**50.5%**
9	Leisure and recreational activities	9	35%	6	26.1%	21	35.6%	23	42.6%	10	41.7%	5	38.5%	**11**	**64.7%**	85	39.4%
6	Health care	**11**	**42%**	5	21.7%	13	22.0%	12	22.2%	2	8.3%	2	15.4%	3	17.6%	48	22.2%
3	Family/caregiving/support network	2	8%	4	17.4%	12	20.3%	12	22.2%	6	25.0%	1	7.7%	4	23.5%	41	19.0%
16	Volunteer/civic engagement	4	15%	5	21.7%	11	18.6%	14	25.9%	4	16.7%	3	23.1%	0	0.0%	41	19.0%
13	Safety and security (public and personal)	5	19%	2	8.7%	8	13.6%	8	14.8%	0	0.0%	0	0.0%	0	0.0%	23	10.6%
2	Education/learning	4	15%	3	13.0%	3	5.1%	6	11.1%	3	12.5%	1	7.7%	2	11.8%	22	10.2%
7	Housing and home ownership	1	4%	0	0.0%	5	8.5%	5	9.3%	1	4.2%	0	0.0%	0	0.0%	12	5.6%
11	Mental health	0	0%	0	0.0%	1	1.7%	4	7.4%	1	4.2%	2	15.4%	2	11.8%	10	4.6%
8	Legal assistance	0	0%	0	0.0%	2	3.4%	4	7.4%	1	4.2%	0	0.0%	1	5.9%	8	3.7%
10	Long-term care	1	4%	0	0.0%	1	1.7%	2	3.7%	2	8.3%	0	0.0%	1	5.9%	7	3.2%
4	Financial security (money/finances)	1	4%	2	8.7%	0	0.0%	1	1.9%	0	0.0%	1	7.7%	1	5.9%	6	2.8%
1	Career/employment	0	0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	5.9%	1	0.5%
14	Spirituality	0	0%	0	0.0%	0	0.0%	1	1.9%	0	0.0%	0	0.0%	0	0.0%	1	0.5%
17	Other (e.g., outreach, I&R, advocacy)	2	8%	3	13.0%	2	3.4%	3	5.6%	2	8.3%	1	7.7%	1	5.9%	14	6.5%

n = number of questionnaires (respondents).
[1]31 municipalities; [2] 25 municipalities; [3] 60 municipalities.

Table MQ_4
Service Delivery Initiatives Municipalities Will Focus on Between Now and 2013

Priority	Item #	Initiatives	Under 1,000		1000-2,499		2,500-4,999		5,000+		Total	
			n=47		n=59		n=51		n=52		n=209	
1	5	Promote health aging through physical activity/fitness/falls prevention.	32	**68.1**	45	**76.3**	43	**84.3**	46	**88.5**	166	**79.4**
2	3	Promote preventative health care, screenings and immunizations.	35	**74.5**	39	**66.1**	37	**72.5**	32	**61.5**	143	**68.4**
3	2	Promote social connections and volunteer/civic engagement in the community.	29	**61.7**	33	**55.9**	30	**58.8**	25	**48.1**	117	**56.0**
4	6	Promote leisure and recreational activities.	25	**53.2**	29	**49.2**	26	**51.0**	25	**48.1**	105	**50.2**
5	10	Promote public and paratransit transportation options.	14	**29.8**	31	**52.5**	28	**54.9**	21	**40.4**	94	**45.0**
6	13	Improve our emergency response capacity for homebound and adult disabled residents.	14	**29.8**	22	37.3	20	39.2	13	25.0	69	33.0
7	14	Re-examine the role of senior centers in the community.	13	27.7	19	32.2	15	29.4	21	**40.4**	68	32.5
8	1	Help prepare residents for its aging population.	14	**29.8**	15	25.4	17	33.3	21	**40.4**	67	32.1
9	7	Help with increasing home ownership costs such as property taxes/fees and water/sewer/utility bills.	5	10.6	18	30.5	8	15.7	14	26.9	45	21.5
10	4	Improve access to mental health services along with screening, education and support programs.	3	6.4	9	15.3	11	21.6	16	30.8	39	18.7
11	9	Expand affordable elder housing capacity and support options.	6	12.8	12	20.3	10	19.6	6	11.5	34	16.3
12	8	Assist elders with home modification, repair and maintenance services.	12	25.5	8	13.6	3	5.9	4	7.7	27	12.9
13	15	Better planning to reflect residents' vision of "livable" community.	2	4.3	5	8.5	8	15.7	5	9.6	20	9.6
15	12	Encourage employment retention, training/retraining and recruitment of older workers.	3	6.4	2	3.4	1	2.0	2	3.8	8	3.8
16	11	Promote pedestrian and driver safety in community design and planning.	0	0.0	1	1.7	2	3.9	0	0.0	3	1.4
14	16	Other (write in)	7	14.9	4	6.8	2	3.9	5	9.6	18	8.6

Building intergenerational relationships through "life long" learning programming.
Build free standing community center.
Care/build a shared community center.
Connecting older adults to programs to help financially
Education, to keep senior citizens informed on current issues of concern to the aging.
Emergency Planning for Seniors
In the process of trying to build an "Adult Life Center."
Lifelong learning opportunities
Nutrition and transportation
Our Van transportation
Outreach and assistance for the (over 80) elders
Promote Multi-Cultural Exchanges
Promote needs for volunteers for medical transport
Strengthen outreach to minority population.
Transportation/personal mobility
Try to expand the Tax Work Off Program which is managed by our office.
Volunteerism

Table MQ_5
Initiatives Municipalities Recommend Elder Affairs to Focus on Between Now and 2013

Rank	Item #	Initiatives	Under 1,000 n=46		1,000-2,499 n=58		2,500-4,999 n=51		5,000+ n=52		Total n=207	
1	14	Improve access/increase public and paratransit transportation options.	**18**	**39.1**	**30**	**51.7**	**29**	**56.9**	**28**	**53.8**	**105**	**50.7**
2	11	Promote healthy aging through physical activities/fitness/falls prevention.	**23**	**50.0**	**27**	**46.6**	**29**	**56.9**	**24**	**46.2**	**103**	**49.8**
3	4	Expand affordable elder housing capacity and support options.	**19**	**41.3**	**33**	**56.9**	**27**	**52.9**	21	40.4	**100**	**48.3**
4	3	Increase home and health care workforce.	**27**	**58.7**	**25**	**43.1**	**25**	**49.0**	17	32.7	**94**	**45.4**
5	7	Invest in outreach to targeted populations to raise their awareness of available services and supports.	15	32.6	**31**	**53.4**	22	43.1	**23**	**44.2**	**91**	**44.0**
5	1	Expand capacity of protective services (abuse, fraud, exploitation, neglect and self-neglect) for elders.	17	37.0	24	41.4	**26**	**51.0**	**24**	**46.2**	**91**	**44.0**
7	2	Improve access to mental health services including screenings and support programs.	11	23.9	20	34.5	23	45.1	**33**	**63.5**	87	42.0
8	13	Promote preventative health including screenings and immunizations.	**25**	**54.3**	20	34.5	11	21.6	12	23.1	68	32.9
9	15	Re-examine the role of senior centers.	11	23.9	20	34.5	13	25.5	16	30.8	60	29.0
10	10	Work with consumers and caregivers as well as providers and direct service workers to monitor service quality and effectiveness.	11	23.9	17	29.3	13	25.5	11	21.2	52	25.1
11	5	Establish a single, coordinated information and access system for all persons seeking long term supports.	8	17.4	13	22.4	15	29.4	13	25.0	49	23.7
12	6	Encourage residents to plan for their medical and non-medical long term care.	11	23.9	12	20.7	11	21.6	7	13.5	41	19.8
13	12	Educate residents about degenerative illnesses, specifically dementia/Alzheimer's Disease.	7	15.2	10	17.2	5	9.8	12	23.1	34	16.4
14	8	Promote financial well being.	9	19.6	5	8.6	5	9.8	5	9.6	24	11.6
15	9	Promote employment retention, training/retraining and recruitment of elders.	1	2.2	6	10.3	9	17.6	6	11.5	22	10.6
16	16	Other (write in)	3	6.5	0	0.0	0	0.0	5	9.6	6	2.9

Better regulate assisted living facilities

Improve nutrition program, provide options

Promote and support local services at the senior centers for improved access and efficiency.

Promote outreach to minority population.

B. Safety and Security

1. Emergency Medical Services (EMS)

Respondents were asked to review their EMS service calls for calendar years 2005, 2006 and 2007 and to indicate if the number of service calls decreased, remained stable or increased. In addition for communities with increased service calls, to report on their average rate of increase, to indicate whether any programs, services or regulations were being initiated to address the anticipated increased, and to give a brief description of the initiatives being undertaken in their communities.

Based on 204 respondents, 55% (n=103) reported EMS service calls increased over the past three years, while 45% (n=84) indicated it remained the same. None indicated a decrease.

Among respondents with increased service calls (Table MQ_6), the mode is a 5% to 10% increase across the three calendar years. Nearly 3 of every 5 reported their average service calls increased up to 10%. Few communities reported service call demand increases of 20% or greater.

Table MQ_6
Community's average rate of increase across the three calendar years

Rate of Increase	Frequency	Percent
Less than 5%	16	15.5
Between 5% to 10%	44	42.7
Between 10% to 15%	20	19.4
Between 15% to 20%	15	14.6
20% or greater	5	4.9
Not available/blank	3	2.9
	103	100.0

Among the communities with increased service calls, 35% indicated programs, services or regulations have been put in place to address the increased call demand for EMS. The remaining 65% indicated no initiatives (20%) and "Unsure" (45%).

In general, the types of initiatives put in place to respond to the increased service call demands include purchasing another ambulance, increasing or improving communication or coordinating efforts with EMS, fire, police, and COA departments, providing CPR training, giving presentations on general safety with a focus on preventing falls, and generating a special needs database or registry. (The brief descriptions of local initiatives are presented in Table MQ_6a in appendix C.)

2. Emergency Management Planning

Should a natural or man-made disaster/threat occur in their communities, respondents were asked whether a registry or record of people was maintained who require additional assistance (e.g., home bound people, elders and adults with disabilities). Slightly over one half of the respondents indicated affirmative, while 22% responded "No" and 26% "Unsure."

Table MQ_7
Registry or record of people who require additional assistance

Municipality maintains a registry	Frequency N=202	Percent	Cumulative Percent
Yes	104	51.5	51.5
No	45	22.3	73.8
Unsure	53	26.2	100.0

Among the 104 municipalities with a registry or record of people who require additional assistance, 51% indicated a single department is responsible for maintaining/updating the registry, 31% reported two departments, and 15% indicated three to five departments shared the responsibility.

Table MQ_8
Number of Departments Responsible for Maintaining/Updating Registry

Department(s)	Frequency N=104	Percent	Cumulative Percent
One	53	51.0	51.0
Two	32	30.8	81.7
Three	11	10.6	92.3
Four	4	3.8	96.2
Five	1	1.0	97.1
Unspecified	3	2.9	100.0

In municipalities with a single department responsible for maintaining and updating the registry, the Council on Aging is cited most often followed by the Emergency Management and the Police department.

Table MQ_9
Department Responsible for Maintaining/Updating Registry

One Department	Frequency N=53	Percent	Cumulative Percent
911 Center/Dispatch*	3	5.7	5.7
All departments get together and discuss once a year	1	1.9	7.5
Board of Health	4	7.5	15.1
Council on Aging	15	28.3	43.4
Emergency Management**	11	20.8	64.2
Fire Department	5	9.4	73.6
Police Department	8	15.1	88.7
Senior Center	1	1.9	90.6
Town Administrator/Manager, Select Board, Town Clerk	5	9.4	100.0

* 911Center/Dispatch may be under the Police, Fire or Emergency Medical Services.
** Emergency Management includes Civil Defense and Emergency Response or Preparedness Team .

In communities with two departments responsible for maintaining and updating the registry, the combination of the COA and Emergency Management is reported most frequently then followed by the combination of the COA and fire department.

Table MQ_10
Two Departments Responsible for Maintaining/Updating Regi stry

Two Departments	Frequency N=32	Percent	Cumulative Percent
Area Agency on Aging & Council on Aging	1	3.1	3.1
911 Center/Dispatch* & Council on Aging	1	3.1	6.3
Board of Health & Council on Aging	3	9.4	15.6
County Sheriff's Department & Senior Center	1	3.1	18.8
Emergency Management** & Board of Health	1	3.1	21.9
Emergency Management** & Council on Aging	6	18.8	40.6
Emergency Management** & Fire Department	2	6.3	46.9
Emergency Management** & Police Department	1	3.1	50.0
Fire & Police Departments	3	9.4	59.4
Fire Department & Council on Aging	5	15.6	75.0
Fire Department & Office of the Mayor	1	3.1	78.1
Fire Department & Senior Center	1	3.1	81.3
Police Department & Board of Health	3	9.4	90.6
Police Department & Council on Aging	2	6.3	96.9
Police Department & Outreach	1	3.1	100.0

* 911Center/Dispatch may be under the Police, Fire or Emergency Medical Services department.
** Emergency Management includes Civil Defense and Emergency Response or Preparedness Team .

Three or more departments responsible for maintaining/updating a registry is shown in Table MQ_10a, appendix D. Emergency Management, Council on Aging, Police, Fire and EMS departments, Board of Health, Social Services and volunteers remain the key participants in maintaining/updating a registry.

With regard to the number of people currently registered who require additional assistance, about half of the communities reported less than 50 people are currently registered (Table MQ_11). Twenty percent indicated 50 to 100 people are currently registered; nearly another 20% indicated 100 to over 900 people are currently registered. About 10% are uncertain or did not specify a number.

Table MQ_11
Number of Residents Who Require Additional Assistance

Number of Residents	Frequency N=104	Percent	Cumulative Percent
Less than 25	21	20.2	20.2
25 to 50	32	30.8	51.0
50 to 75	10	9.6	60.6
75 to 100	10	9.6	70.2
100 to 150	5	4.8	75.0
150 to 200	4	3.8	78.8
200 to 300	2	1.9	80.8
300 and more (e.g., 578 or over 900)	9	8.7	89.4
Other: Unsure, unknown	7	6.7	96.2
Unspecified	4	3.8	100.0

3. Evidence-Based Prevention Programs

One of EOEA's initiatives is to promote individual wellness. In this endeavor, respondents were asked to indicate the number of unique (unduplicated) evidenced-based programs that were offered in their communities in the last 12 months. In addition, for communities that offered evidenced-based programs, respondents were asked to indicate the number and name of each falls prevention program.

The AoA's definition of evidence based prevention programs was used, that is, "…interventions … that have been proven effective in reducing the risk of disease, disability, and injury among elderly." Examples of evidenced based prevention programs are Chronic Disease Self Management Program, Healthy Eating for Successful Living in Older Adults, and A Matter of Balance (falls prevention).

Based on AoA's definition, 77% (n=156) offered evidenced-based prevention programs (i.e., 52% [n=105] offered 1–5, 19% [n=38] offered 6–10, and 6% [n=13] held 11 to over 25), and 23% (n=46) none. Among the 156 communities with evidenced-based programs, 70% (n=110) offered programs specifically designed for falls prevention and 30% (46) none. Among the communities offering falls prevention programs, 45% (n=50) offered one, 35% (n=39) two, 16% (18) three to five, and 3% (n=3) six or more. In general, 54% of the communities offered evidence-based programs of which one was specifically designed for falls prevention.

Evidence-based falls prevention programs offered in the communities include:

"Fall Prevention" from Lahey Clinic
A Matter of Balance
Fall Prevention Seminar from local Assisted Living
Fallon- Falls and Risk to Elders
Falmouth Hospital Rehabilitation Services
Hallmark Health
Health Fair Speakers
Live for Life (YMCA) model
Nursing Home Speakers HVES, Inc. Speaker
Oakwood Reh Center of Webster
PACE (People with Arthritis Can Exercise)
Project Osteo – osteo prevention
Quaboag Valley Nursing Association Program
Wing Memorial Hospital Nurse Program
Ramsey Rehab - Balance and Testing for Balance
Ramsey Rehab - Vertigo Ramsey Rehab-falls prevention
VNA Falls Prevention programs

4. Strength, Flexibility and Cardiovascular Activities.

To ascertain the promotion of individual wellness in the communities, respondents were asked if they offered physical activities programs, and if affirmative, to list in descending order of use

their five most popular physical activity programs. In addition, an inquiry was made if elders had access to fitness equipment, and if affirmative, to list the five most popular equipment in use.

The Centers for Disease Control and Prevention's definition of regular physical activity was used, that is, participation in three or more 20-minute sessions activity that makes the person sweat or five or more 30 minute sessions of slower activity such as walking. Since ranked order activities were requested, 5 points was assigned to the first activity and one point to the fifth activity. Weighted values were added for each activity and also summed under a common heading (e.g., dancing). The activities were classified under four major components: Muscular Endurance, Balance including breathing and posture, Flexibility and Stretching, and Muscular Strengthening.

Among 200 respondents (208 municipalities), 92% offered physical activity programs. As shown in Table MQ_12, three of the five top physical activities pertained to muscular endurance and the remaining two pertained to balance including breathing and posture. **Aerobics** is the primary physical activity offered in the communities followed by **dancing, yoga and meditation, tai chi, and walking**. Exercise/fitness, water exercises, Wii, bowling, bicycling and voll eyball are other muscular endurance activities offered. Pilates and Qigong are other activities for balance. Activities supporting Muscular Strengthening is third, and Flexibility and Stretching last.

Table MQ_12
Part B. 4 Strength, Flexibility and Cardiovascular Activities

Components	1st		2nd		3rd		4th		5th		Weighted		Rank
	N	WN	N	WN	N	WN	N	WN	N	WN	ST	Total	
Muscular endurance													
Aerobics	7	35	4	16	2	6	4	8	2	2	67	**548**	
Low impact aerobics	21	105	12	48	6	18	4	8	1	1	180		
Aerobic w/ weight training	25	125	5	20	2	6	1	2	2	2	155		
Chair aerobics	8	40	11	44	6	18	7	14	6	6	122		1
Aerobic w/ strength training	2	10	1	4							14		
High Impact aerobics	1	5									5		
Medium impact aerobics	1	5									5		
Dancing			1	4							4	**343**	
Line (inc country line)	15	75	21	84	22	66	11	22	16	16	263		
Zumba/Zumba Gold	1	5	4	16	2	6	3	6	2	2	35		
Belly									1	1	1		
Tap	2	10	1	4			1	2	1	1	17		2
Folk			1	4	1	3					7		
Ballroom					1	3			1	1	4		
Round			1	4							4		
Senior					1	3					3		
Jazzercise							1	2			2		
Walking	1	5	4	16			2	4	2	2	27	**210**	
Walking clubs/groups	8	40	9	36	1	3	12	24	8	8	111		
Nordic walking/hiking					15	45	1	2	2	2	49		5
Indoor					6	18	1	2			20		
Outside (trail)							1	2	1	1	3		

Exercise/fitness (unspecified) class	12	60	2	8	3	9	1	2	1	1	80	**110**	
Senior fitness/exercise	2	10	1	4			1	2			16		
Women's exercise	1	5									5		
Cardio abs					1	3			1	1	4		
Elliptical/exercise machines					1	3					3		
Men's exercise/fitness									2	2	2		
Water exercises	2	10					2	4			14	**72**	
Swimming			1	4	8	24	2	4			32		
Water aerobics	1	5	2	8			5	10	3	3	26		
Wii					2	6	6	12	12	12	30	**30**	
Bowling	1	5	1	4							9	**9**	
Bicycling	1	5									5	**5**	
Volleyball (including chair volleyball)									2	2	2	**2**	
Balance including breathing and posture													
Yoga & Meditation	20	100	21	84	15	45	24	48	13	13	290	**338**	
Chair	1	5	1	4	4	12	1	2	1	1	24		
Gentle	1	5	1	4							9		
Senior or advanced					1	3					3		3
Yoga & Meditation	1	5									5		
Laughter yoga			1	4							4		
Yoga + Yoga H_20					1	3					3		
Tai chi	8	40	28	112	21	63	17	34	19	19	268	**269**	4
Tai chi w/ weights									1	1	1		
Pilates					2	6	2	4	1	1	11	**25**	
Pilates class					1	3	1	2			5		
Beginner			1	4							4		
Intermediate	1	5									5		
Qigong			1	4	1	3	1	2			9	**9**	
Better Balance					1	3					3	**5**	
Balance training							1	2			2		
Flexibility and Stretching													
Senior Stretch	1	5	1	4	1	3					12	**83**	
Sit and stretch	2	10									10		
Stretch and tone			2	8	1	3			1	1	12		
Stretching					2	6	1	2			8		
Chair exercise	3	15	5	20			2	4	2	2	41		
Muscular Strengthening													
Strength/weight training	8	40	9	36	4	12	5	10	1	1	99	**109**	
S/W training for frail elders	1	5			1	3	1	2			10		
Strength training (generic)	5	25	4	16	3	9			1	1	51	**63**	
Strength and balance			2	8	1	3					11		
Men's strength training									1	1	1		
Weight training	4	20			1	3	1	2			25	**25**	
Specific Physical Activity Program													
Project Osteo -- osteo prevention	8	40	8	32	1	3	4	8			83	**133**	
PACE - People w/ Arthritis Can exercise; Sit & be fit	3	15	2	8			2	4	1	1	28		
Arthritis exercise			1	4	5	15					19		
Better Bones					1	3					3		
Fit for the Future	1	5			5	15					20	**20**	
A Matter of Balance			1	4	3	9					13	**13**	
Fitness center	1	5							1	1	6	**6**	
Young at Heart	1	5									5	**5**	
Massage			1	4							4	**4**	
Super Fit					1	3					3	**3**	
Live for Life (YMCA) model									1	1	1	**1**	

With regard to fitness equipment, among the 183 respondents who offered physical activity programs, about 2 of every 5 communities also had fitness equipment at their centers. Fitness equipment most in use by elders are weights, followed by resistance bands, treadmills, upright and/or recumbent bicycles, and elliptical machines (Table MQ_13). Fitness equipment reportedly most in use by elders are to develop/maintain muscular strength followed by endurance. Other fitness equipment included balls, strength fitness machines, Wii, yoga blocks and rowing machines.

Table MQ_13
Fitness Equipment Most in Use

Most in Use / Weighted Value / Equipment	1st	2nd	3rd	4th	5th	Weighted Value		Rank
	5	4	3	2	1	ST	T	
Weights	4	1		1		26	261	
Free weights	32	7	2	2	1	199		
dumbbells	1					5		
leg weights		1			1	5		1
weighted balls 2,4,6,8,10#				1		2		
Hand/arm weights	4					20		
Weight machine		1				4		
Resistance bands	5	24	4	1		135	140	2
Resistance bands and free weights	1					5		
Balls			1			3	15	
Pilates balls		1	1			7		
Yoga balls								
Stability balls						0		
Balance balls	1					5		
Strength fitness machines							6	
Koko Machine			1			3		
Back extension machine			1			3		
Treadmill	17	5	4	2		121	121	3
Upright and/or recumbent bicycles	2	12	11	2	1	96	96	4
Elliptical machine	1	5	1	2		32	35	5
Nustep – upper and lower				1		2		
Windjammer – upper					1	1		
Wii			1	1		5	5	
Rowing machine					1	1	1	
Yoga blocks	1					5	5	
Other -- Ergometer			1			3	3	

C. Community Preparedness

An inventory of activities or practices (three to 13) was listed for 20 areas associated with livable communities and aging in place literature. Respondents were asked to indicate the status of each activity using the following:

Exists = The activity/practice exists in the community.
Dialogue = Although the activity/practice does not exist in the community, a dialogue is occurring.
None = The activity/practice does not occur in my community.
N/A = The activity/practice does not apply to my community.

Table MQ_14 presents specific activities wherein 80% or more of the respondents reported services exist in their communities. Almost universally offered in the communities are routine vaccinations against influenza and pneumoco ccal disease, meal services for elders, and referral services to locate general information about caregiver services.

Table MQ_14
Specific Activities Available in 80% or More of the Communities

Area	Activity	% Exists
Community Governance	Established connections and communications between the COA and other municipal departments.	87.8
	A COA director recognized as a municipal department head.	86.8
	Established connections and communication between the COA and other municipal departments.	85.8
	Information about the COA on the website.	82.7
Social Services	A central phone number that people can call when they need assistance but do not know where to turn.	84.3
	A single entry point or one-stop-shop for elder resources and services.	80.8
Education/Learning	Community sponsored events that promote culture such as concerts, shows, celebrations, etc.	90.9
	Information programs on topics of interest to elders offered at community centers or other public facilities.	89.3
	Community sponsored events that prom ote fine arts and crafts such as water color, knitting, quilting, needlepoint, etc.	8736
	Library information programs such as book discussions and speakers on topics of interest to elders.	83.2
Family/Caregiving	Referral services to locate general infor mation about caregiver services.	94.4
Food and Nutrition	Meal services for elders (e.g., home delivered meals, congregate meal sites, transportation to meal sites).	96.4
	Places for minimizing hunger/food insecurity (e.g., identifying places to buy affordable food; local food banks or pantries).	85.8
Financial Security	Education and information about financial fraud and predatory lending.	88.9
	Fuel oil or other financial assistance for heating.	88.9
	Assistance for elders in preparing and filing taxes .	87.9
	Assistance with basic needs such as a food or clothing pantry.	85.9
	Property tax relief for elders with limited incomes.	85.9
Health Care	Preventative immunizations such as influenza and pneumonia.	95.4
	Health education programs on topics im portant to elders.	90.9
Housing/Home Ownership	Subsidized housing facilities.	83.8
Legal Assistance	Programs or seminars on legal issues of interest to elders	87.2
Leisure/Recreational Activities	Community-sponsored events that promote social interactio ns such as drop in centers, picnics, etc.	89.8
Long-term Care	Routine vaccinations against influenza and pneumococcal disease.	96.4
Physical Activity	Exercise and wellness programs specifically tailored to elders	91.3
Volunteer Opportunities/ Civic Engagement	Transportation to the polls for elders on Election Day.	80.5

An overall aggregate value for each area was calculated by summing responses to Exist, Dialogue and None and then dividing by the total number of responses. The aggregate values are presented in descending order in Table MQ_15. The status of each activity within ea ch area is presented in Table MQ_15a, appendix D.

Table MQ_15
Community Preparedness

A1 Current	A2a Future	A2b EOEA	Rank Order	Areas to Support Elders to Remain Independent	N	Status (Percent)		
						Exist	Dialogue	None
			1	9. Financial Security	198	**85.2**	4.1	10.7
			2	12. Legal Assistance	195	**76.3**	4.5	19.2
			3	6. Education/Learning	197	**74.5**	6.7	18.7
2	1	2	4	16. Physical Activity, Fitness and Falls Prevention	195	**74.2**	7.9	17.9
			5	2. Building/Zoning Codes	183	**73.0**	12.7	14.3
			6	4. Social Services	198	**72.9**	12.4	14.7
3			7	8. Food and Nutrition	197	**71.3**	7.8	20.9
			8	7. Family/Caregiving/Support Networks	198	**71.1**	9.3	19.6
	4		9	13. Leisure and Recreation	197	**65.4**	4.3	30.3
			10	1. Community Governance	197	**64.1**	20.4	15.5
	2		11	10. Health Care	197	**63.9**	3.7	32.4
		4	12	14. Long-term Care	197	**62.3**	9.2	28.5
			13	18. Spirituality	194	**57.6**	11.8	30.6
		5	14	17. Safety and Security	196	**54.5**	19.3	26.2
	3		15	20. Volunteer Opportunities/Civic Engagement	195	**53.9**	11.0	35.1
1	5	1	16	19. Transportation System	195	**50.1**	5.4	44.5
			17	3. Pedestrian and Driver Safety	193	**49.9**	15.2	34.9
		3	18	11. Housing and Home Ownership	197	**47.9**	13.4	38.7
			19	15. Mental Health	196	**46.9**	6.7	46.3
			20	5. Career/Employment Services	184	**21.0**	4.9	74.1

According Table MQ_15, services pertaining to Financial Security and Legal Assistance are offered in more than 75% of the communities surveyed. Education/Learning, Physical Activity, Fitness and Falls Prevention, Building/Zoning Codes, Social Services, Food and Nutrition, Family/Caregiving/ Support Networks, and Leisure and Recreation are offered in 65% to 75% of the communities surveyed. In at least half of the communities surveyed, service activities under Community Governance, Health Care, Long-term Care, Spirituality, Safety and Security and Volunteer Opportunities or Civic Engagement were available. Least amenable service activities for elders are Pedestrian and Driver Safety, Housing and Home Ownership, Mental Health, and Career or Employment Services.

Communities' future focus areas and their recommendations for EOEA suggest joint efforts for Physical Activity, Fitness and Falls Prevention, and Transportation initiatives. Setting aside physical activity, fitness and falls prevention, communities plan to focus on services available in less than 70% of the communities statewide. While communities plan to focus on Leisure/Recreation, Health Care, and Volunteer/Civic Engagement activities, they recommended EOEA to address Long-term Care, Safety and Security, and Housing/Home Ownership services.

Since service availability is not uniform across the communities, further analyses were undertaken to identify where services begin to differentiate based on community size. The analyses were made

for four recommended areas by municipalities for EOEA to focus on: Transportation, Physical Activities, Housing and Home Ownership, and one item under Safety and Security. Communities were grouped into four categories: Small = Under 1,000 elders, Low -Medium = 1,000 to 2,499 elders, High-Medium = 2,500 to 4,999 elders, and Large = 5,000 and over elders in the community.

Transportation System

For 13 activities listed under this area, the existence of services ranged as follows:

Small size communities	7% to 52%
Low-Medium size communities	14% to 72%
High-Medium size communities	21% to 79%
Large size communities	49% to 100%

Community size matters regarding availability of specific transportation services. Small communities do not differ from Low -Medium communities except for discounted taxi cab fares (item 4), and access to out-of-town travel (item 6). Seven percent of Small communities offer discounted taxi cab fares in contrast to 28% of Low -Medium communities. Access to out -of-town travel options exist in 26% of Small communities in contrast to 56% in Low -Medium communities.

A statistically significant difference ($p < .05$) exists between Small and High -Medium communities for all transportation items except item 10, the existence of a comprehensive land -use plan coordinated with transportation planning. For item 10, a statistically significant difference is found between Small and Large communities only.

Community size is factor that distinguishes each of the four communities from another for item 6, that is, "Nearby access to out -of-town travel options such as air, bus, and train." Out -of-town travel options are available in 26% of Small communities. Low - and High-Medium communities both reported similar amount of service availability regarding out -of-town travel options (57% and 61%, respectively), however, differences occur in the extent of dialogue occurring in these communities. In Low-medium communities no dialogue is occurring in contrast to 18% of the High -Medium communities. Out-of-town travel options exist in 88% of Large communities in contrast to 26% in Small, 57% in Low-Medium, and 61% in High-Medium communities.

Physical Activity, Fitness and Fall Prevention

For five activities listed under this area, the existence of services in the communities ranged as follows:

Small size communities	26% to 71%
Low-Medium size communities	47% to 96%
High-Medium size communities	64% to 100%
Large size communities	80% to 100%

Statistically significant differences were found for all (5) activities listed under this area. Differences appear between Small and Low -Medium communities with the availability of activities

favoring communities with greater numbers of elder residents. Across all items, no statistically significance differences ($p < .05$) were found between Low -and High-Medium communities, and between High-Medium and Large communities. Physical activity, fitness and fall prevention activities are likely offered as community size increases.

Housing and Home Ownership

For eight activities listed under this area, the existence of services in the communities ranged as follow:

Small size communities	7% to 48%
Low-Medium size communities	17% to 91%
High-Medium size communities	22% to 97%
Large size communities	20% to 100%

No differences were found between Low -Medium and High-Medium communities across all items. Community size is not a factor for the existence of modification of municipal services for elders (item 7). However, it is a factor for availability of "subsidized housing facilities" (item 8) and appears between Small and Low -Medium communities. Community size is also a fac tor for activity 1, that is, a community housing assessment completed in the past three years that projects future housing needs for various populations. The difference appears between Small and High -Medium communities.

"A service to mediate between elders and contractors when problems arise" (item 3) and "assessments to help elders identify opportunities to modify their homes for better function and safety" (item 5) exists between Low -Medium and Large communities.

"A program or service to assist communi ty members of limited means with interior and exterior modifications to home" (item 2), "an adequate number of licensed contractors who do interior and exterior modifications to the home" (item 4), and "assistance in home weatherization" (item 6) exist in Large in contrast to Small communities, that is, 60% vs. 26%, 70% vs. 42%, and 80% vs. 48%, respectively. The magnitude of differences between Small and Large communities is statistically significant ($p < .05$) for these three items.

Safety and Security (Item 4 Only, Protective Services)

Among nine items under Safety and Security, item 4 pertained to elder abuse, fraud, and neglect. The availability of services by community size is:

Small size communities	53%
Low-Medium size communities	76%
High-Medium size communities	78%
Large size communities	92%

Community size is a factor between the availability of this service activity in Small and Low -Medium size communities. No statistically significant differences ($p < .05$) were found between Low -Medium

and High-Medium communities, and between High-Medium and Large communities. While the existence of this activity is not as readily available in small communities in comparison to larger communities, this item is not a top five focus area for Small communities.

V. Survey of Elder Service Needs

A three-part questionnaire was posted on the 800AgeInfo website from August 15, 2008 through November 15, 2008, and extended through December 15, 2008. Although posting a web-based questionnaire requires the respondent to have access to a computer, this avenue was newly attempted to incorporate electronic technology as the forthcoming standard of practice to gather information from the general public.

While the three-part questionnaire appears lengthy, it was designed and tested for respondents to complete within five minutes. Prior to responding to Part I, Service Needs, the respondent is asked to indicate where s/he first learned about the survey (which are the same items listed under Part A.1 of the Municipal Questionnaire). After indicating the source, the respondent is asked to select up to three service areas most in need of assistance. The software then directed the respondent to addition items (eight to 16) based on the service area selected earlier. If the respondent had no service needs, s/he was directed to Part II.

In Part II, the respondent is asked to select up to five areas for EOEA and his/her community to focus on between now and 2013. Twelve of 14 items listed under recommendations for EOEA, and 14 of 15 items listed under recommendations for the community were similar to those listed in the MQ.

Part III is the standard, optional section for gathering socio-demographic characteristics. In Part III, the respondent had the option to answer nine socio-demographic items. The zip code was requested to identify statewide geographical representation. The standard gender, race, Spanish, Hispanic or Latino heritage, age range, employment status, housing status, total annual household income, and informal caregiver status were requested.

At the forefront, concerns were expressed that the respondents would likely be above the poverty level and there would be under-representation from the non-majority respondents, Spanish, Hispanic or Latino heritage respondents, residents residing in the rural areas, and speakers of languages other than English. We anticipated a response rate of approximately 300-500 people; a very small number in comparison to over 5,000 elders who completed the mailed questionnaire for the 2005 Needs Assessment Study. In addition, we anticipated that the respondents would likely learn about the questionnaire from people familiar with the aging network, primarily the AAAs, ASAPs, or COAs.

In an attempt to reach respondents not familiar with AAAs, ASAPs, and COAs, EOEA obtained lists of minority community agencies from the State Office of Diversity, contacted the Massachusetts Regional Library System to post a flyers in local libraries, placed a notice in state employees pay advice through the State Human Resources Network, and requested specific associations for assistance in disseminating the availability of questionnaire.

A. Respondents

A total of 549 respondents clicked on the web-based questionnaire and six completed a paper version. After removing blank questionnaires and records with only socio-demographic responses, 521 records were available for analyses.

The major sources from which respondents learned about the survey were membership notifications from an organization or association, the AAAs, and the ASAPs (Table GP_1). The bulk of respondents indicating membership notification were members of the Eastham Part Time Residents Tax Payer Association. Secondary sources were a newsletter or local paper, colleagues, friend or family members and the Councils on Aging or Senior Centers.

Table GP_1
How respondent first learned about the survey
Multiple responses accepted; N=521

Source	N	Percent
Membership notification from an organization/association	128	24.6
Area Agency on Aging (AAA)	105	20.2
Aging Services Access Points (ASAP)/Home Care Corporations	90	17.3
Newsletter or local paper	49	9.4
Colleague, friend or family member	49	9.4
Council on Aging/Senior Center	48	9.2
State Human Resources Network (pay advice)	38	7.3
Surfing the web, website, internet, searching web, etc.	21	4.0
800AgeInfo	13	2.5
Massachusetts Regional Library System	12	2.3
Attendance at a meeting or event	9	1.7
Elder Affairs/SHINE Program/ADRC	8	1.5
Do not recall	4	0.8
Local radio or cable TV station	1	0.2
Home care or personal care attendant	1	0.2

Among the respondents (Table GP_2, appendix E), 96% (n=501) were residents of Massachusetts, 2% (n=12) out-of-state residents, and 2% (n=8) unknown. Massachusetts respondents reside across the 23 AAAs; however, 2 of every 5 came from three AAAs (i.e., Cape Cod & Island, Central Massachusetts, and Merrimack Valley). An unanticipated pattern among the respondents occurred, that is, 22% of the residents (approximately 1 of every 5) came from a single AAA, Cape Cod & Island, and specifically from the municipality of Eastham. As a result, some findings will be presented by the single AAA and all others combined. Also, in contrast to past need assessment survey administrations where respondents were all 60 years and older, respondents in this survey administration were also under age 60. As a result, some analyses will be presented by age groups, that is, under 60 (ages 18-59) and 60 and over.

The distribution of respondents deviates from the statewide socio-demographic characteristics with female respondents out-numbering male respondents 3 to 1. Among respondents 60 and over who indicated their race, the overwhelming majority is white, that is, 97.6% in contrast to 91 .9% according to the 2005-2007 American Community Survey 3-Year Estimate (ACS). Only 1.4% vs. 3.5% is Black, 1.0% vs. 2.6% Native Americans and Asians combined, and 2.3% vs. 0.5% multi-racial. Less than 1.0% of the respondents indicated Spanish, Hispanic o r Latino heritage.

By age groups for respondents 18 and over, according to the 2005-2007 ACS, 77% of Massachusetts residents are between 18 and 59 and 23% 60 years and over. In this survey, 41% (n=208) are between 18 and 59 and 59% (n=305) 60 years and ov er. The vast majority (64%) are 50 to 69 years of age; 83% are 50 years and older.

In terms of employment, there is an over representation of respondents who are employed for both age groups. Based on the 2005-2007 ACS, 74% are employed for persons und er 60 years and 11% for persons 60 and over. For the statewide respondents under 60 years of age and 60 and over, 96% and 52% were employed, respectively.

With regard to housing, an over representation of home owners especially among 60 and over respondents also occurred. Statewide, 65% are home owner and 35% renters. Nearly three-quarters of the under 60 respondents are home owners. For residents 60 and over, the 2005 -2207 ACS shows 72% owner occupied and 28% renter-occupied in contrast to 87% and 10%, re spectively, of the survey respondents.

Since Title III funds are targeted for low-income household, inquiry about household size and total annual household income were generated using the 2008 Poverty Level Guideline. According to 2005-2007 ACS, 9.0% of residents 60 and over in Massachusetts are under 100% of the federal poverty level. For the under 60 respondents, the closest estimate from the ACS shows 9.3% below the poverty level for 18-64 year old. Among the survey respondents, 2.3% are below the po verty level (0.6% for respondents under 60 and 3.5% for respondents 60 years and over). More than half of the statewide respondents indicated income at or above 400% of the poverty level.

Finally, 492 respondents indicated whether they were an informal ca regiver to one or more persons. Overall, about 2 of every 5 were an informal caregiver to one or more persons. Caregivers tended to be under 60 for 52% (n=104) in contrast to 29% (n=84) of those 60 years indicated they served as an informal caregiver. The proportion indicating serving as an informal caregiver is gender neutral; however, among those who are informal caregivers, 1 in 6 men in contrast to 1 in 3 women served as a caregiver to more than one person.

For the 130 caregivers who cared for another , more than a third indicated they cared for their mother (step-mother), followed by a spouse, father (step-father) or friend/neighbor/other (FNO). These four relations constituted 76% of persons cared by another. For the 58 who indicated they provided informal caregiving to more than one person, two thirds were under 60 and were likely caring for both parents (19%). Another 5% - 9% each indicated FNO, in-laws, and grandchildren.

In summary, 3 of every 4 respondents were females instead of an overall 48% male and 52% female distribution. Nearly all respondents were white and not of Spanish, Hispanic or Latino heritage.

More than 60% were between 50 to 69 years of age; more than 80% 50 years and over. Nearly all (96%) of the respondents under 60 and more than half (52%) of the respondents 60 and over were employed in contrast to 74% and 11%, respectively, statewide. Regarding homeownership, 76% and 87% of the respondents under 60 and 60 and over, respectively, were homeowners, in contrast to 65% statewide. Less than 3% of the respondents were 100% below the federal poverty guideline in contrast to approximately 9% statewide. Finally, 2 of every 5 were informal caregivers and likely females under 60 years of age. Overall, statewide respondents were primarily of the majority race, home owners, employed, above the poverty level and between 50 and 69 years of age.

B. Service Needs

Statewide respondents were asked to indicate up to three areas of service needs and by priority order. A point system was used to determine service priorities among the respondents. Three points were assigned to priority 1, two points to priority 2, and one point to priority 3. Weighted values were summed across respondents and divided by the total responses. (Weighted values were not divided by the number of respondents because the respondents indicated one, two or three priorities.)

Chart GP_1 shows the 16 areas of service needs in descending order of voiced priority for all respondents, respondents under age 60 , and respondents age 60 and over. The corresponding weighted values by age groups (Table GP_3a) and location (Table GP_3b) are included in appendix E.

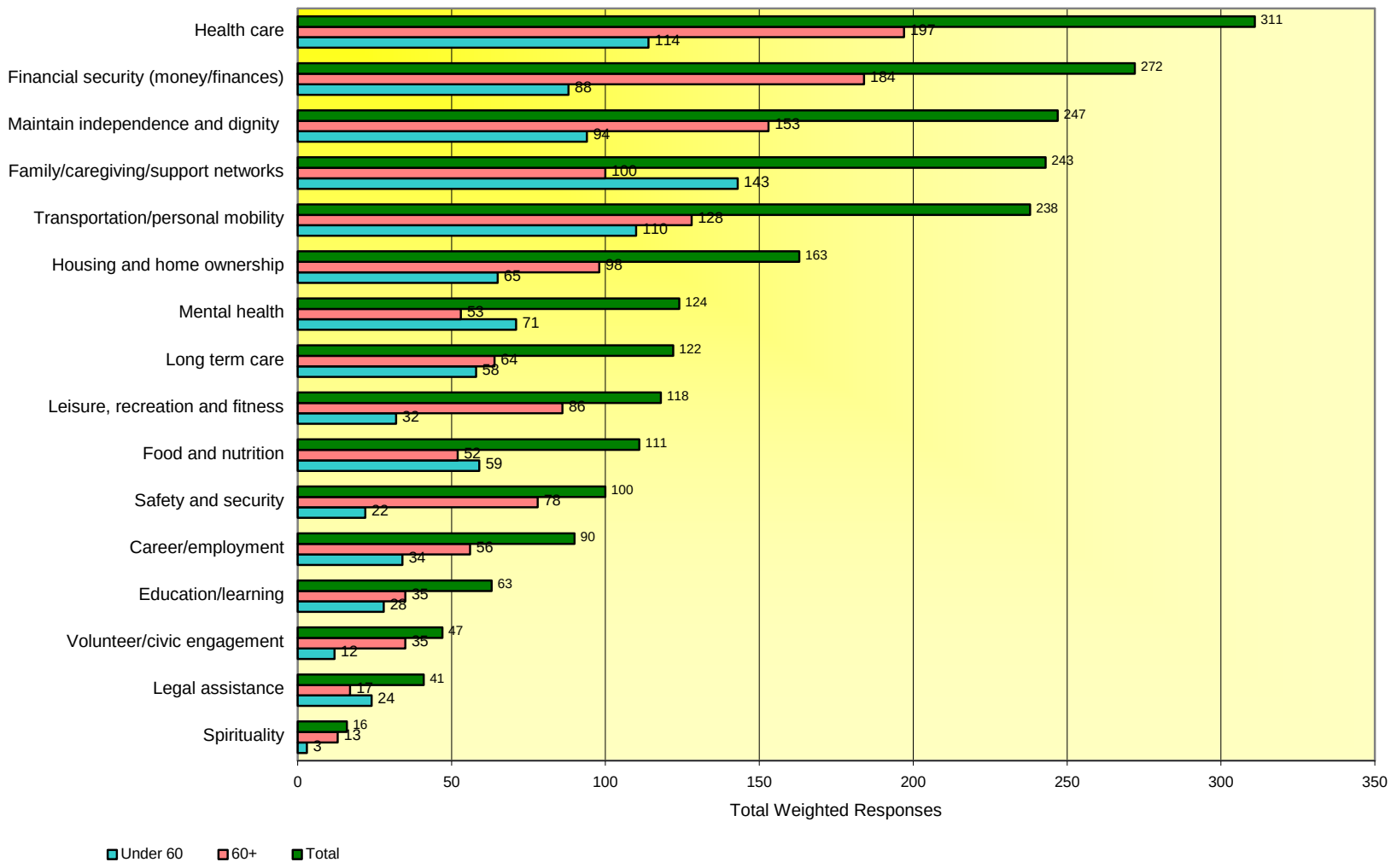
Across the statewide respondents, **Health care** is the primary area of service need followed by **Financial security** (money and finances) and **Maintain independence/dignity**. When broken down by age groups, the same pattern holds for respondents 60 and over; however, Family/caregiving/ support networks services is ranked first followed by Health Care and Transportation/personal mobility for respondents under 60. By location, Health care is also primary for respondents. For the single AAA, Financial security is ranked second followed by Leisure, recreation and fitness. For the 22 AAAs, Family/caregiving/support networks ranks second followed by Financial security.

Across respondents, the secondary service priorities are housing and home ownership, mental health, long-term care, leisure, recreation and fitness, food and nutrition, safety and security, and career/employment. Service needs pertaining to education/learning, volunteer/civic engagement, legal assistance, and spirituality are minor in comparison to the top three.

Specific service needs based on 50 or more respondents are presented in Table GP_4 with all results available in Table GP_4a, appendix E. These items represent about 20% of nearly 200 items listed in the questionnaire.

For the 15 items listed under Health Care, the specific service concerns are affordable health insurance, paying for out-of-pocket health care costs, understanding their health insurance plans and the health care systems, managing and paying for medications, and getting and paying for dental care.

Chart GP_1 -- Areas of Service Needs by Age Groups



Specific service assistance cited under Financial Security includes help with home ownership expenses (e.g., mortgages, utility bills, and local taxes), affording health care, affording groceries, paying for mental health services, and improving their financial situation.

Regarding Maintaining Independence, specific assistance revolves around adapting their homes as their health or physical needs change, accessing transportation that is flexible and available on short notice, and maintaining social connections with others.

Specific services under Family/Caregiving pertain to preparing for a family's member or one's long-term care, finding reputable home care providers, and obtaining general information about caregiving and caregiver services. Accessing and paying for Mental Health services are a voiced need along with services to address depression, grief, loss or bereavement.

Service needs under Long-term Care include learning about long-term care options and securing workers to provide homemaker, personal care and chore services.

Finally, service needs under Safety and Security revolves around learning about injury and accident prevention, and having safe neighborhood amenities (i.e., well maintained side walks with visible curb cuts and adequate street lighting for pedestrians).

Table GP_4
Major Specific Service Needs within Each Area

Item	Specific Needs	N	Percent
	F. Health Care (n=139)		
1	affording health insurance.	89	64.0%
4	paying for out-of-pocket health care costs.	81	58.3%
2	understanding my health insurance plan and health care system.	71	51.1%
6	affording and/or managing my medications.	67	48.2%
12	help with getting and paying for dental care.	52	37.4%
	D. Financial Security (money/finance) (n=131)		
3	help with housing expenses such as mortgage, utilities and home repairs.	79	60.3%
4	help with health, medical or medication costs such as co payments.	79	60.3%
12	how to protect my money, assets or property.	66	50.4%
9	ways to improve my financial situation.	65	49.6%
8	learning about local tax/fee relief programs for elders.	58	44.3%
	K. Maintain Independence/Dignity (n=123)		
3	adapting my home to my changing health or physical needs.	64	52.0%
1	getting my financial house in order so I can remain lifelong in my home.	62	50.4%
8	having accessible and convenient public transportation options.	61	49.6%
11	maintaining social connections with others.	61	49.6%
	O. Transportation/Personal Mobility (n=123)		
6	ability to have pickup appointments on short notice; not days in advance.	82	66.7%
3	finding escort services for medical and other appointments.	72	58.5%
5	having non-medical paratransit services, that is, passenger transportation with no fixed routes or schedules.	70	56.9%
1	learning about transportation programs for elders/adults with disabilities.	65	52.8%

	C. Family/Caregiving/Support Networks (n=119)		
1	how to prepare for my or family member's long-term care.	71	59.7%
2	finding reputable providers of home care services.	65	54.6%
3	obtaining general information about caregiving and caregiver services.	58	48.7%
	G. Housing and Home Ownership (n-87)		
1	finding affordable housing.	43	49.4%
7	help with home repairs.	43	49.4%
8	help with property taxes and/or fees.	41	47.1%
9	help with utilities bills.	41	47.1%
	L. Mental Health (n=65)		
1	accessing mental health services.	35	53.8%
8	securing services to address depression or suicide.	30	46.2%
5	paying for mental health services.	29	44.6%
9	securing services to address loss, grief or bereavement.	28	43.1%
	J. Long-Term Care (n=65)		
2	learning about ways to pay for long-term care needs.	48	73.8%
1	learning about long-term care option for myself or another.	43	66.2%
5	securing personal care services.	28	43.1%
6	securing homemaker/chore services.	28	43.1%
	I. Leisure, Recreation and Fitness (n=66)		
1	learning about available leisure and recreational opportunities in my community.	44	66.7%
11	participating in physical activities (e.g., dancing, swimming, walkin g clubs).	43	65.2%
	E. Food And Nutrition (n=56)		
1	affording groceries.	36	64.3%
	M. Safety and Security (n=51)		
10	learning about injury and accident prevention practices.	33	64.7%
8	having well-maintained, unobstructed sidewalks with visible c urb cuts.	29	56.9%
7	having adequate street lighting for pedestrian safety and security.	28	54.9%

C. Service Areas of Focus

1. Recommended Services for Elder Affairs

Recommended areas for EOEA to focus on between now and 2013 are shown in Tables GP_5a and GP_5b, appendix E. Based on 510 respondents, the recommended top five service priorities are:

1. Expand affordable elder housing capacity and support options
2. Improve access/increase public and paratransit transportation options
3. Increase home and health care workforce
4. Promote fitness, exercise and recreational activities including injury/falls prevention programs
5. Establish a single, coordinated system of information and access for all persons seeking long-term supports

The first three priorities are age neutral; however, "Improve access to mental health services including screenings and support programs" and "Encourage residents to plan for one's medical and non-medical long-term care" are ranked fourth and fifth, respectively, for respondents under 60.

Although in different rank order, the first four priorities are the same for respondents 60 and over; however, their fifth priority is "Promote preventative health including screenings and immunizations."

By location, the same service priorities and in the same rank order apply to the 22 AAAs. For the single AAA though, "Promoting preventative health including screening and immunizations", and "Encouraging residents to plan for one's medical and non-medical long-term care" are in the forefront with "Expanding affordable elder housing" and "Establishing a single, coordinated system of information" ranked lower.

2. Recommended Service Areas for Your Community

For the same 510 respondents, the recommended top five service initiatives for their communities to address are (Table GP_6a, appendix E):

1. Assist elders with home modification, repair and maintenance services;
2. Expand affordable elder housing capacity and support options;
3. Improve access/increase public and paratransit transportation options;
4. Expand options to help elder homeowners with increasing cost of home ownership; and
5. Promote fitness, exercise and recreational activities including injury/falls prevention programs.

The five priorities are the same for respondents 60 and over. Respondents under 60 selected the same first four priorities with promoting fitness, exercise and recreational activities ranked seventh. For respondents under 60, rounding off the top five is "Improve access to mental health services including screening and support programs."

By location (Table GP_6b, appendix E), residents in the 22 AAAs selected the same initiatives and in the same order. Respondents from the single AAA also indicated service initiatives 1, 3, 4, and 5; however, they identified "Promoting preventative health care, screenings and immunizations" among their top five. Expanding affordable elder housing capacity and support options is ranked sixth for respondents from the single AAA.

Overall, health care, financial security, maintaining independence and dignity, family/caregiving/ support networks, transportation, and housing/home ownership are the essential areas of service needs. Respondents recommended for both EOEA and their communities to focus on (a) expanding affordable elder housing capacity and support options, (b) improving access or increasing public paratransit options, and (c) promoting fitness, exercise and recreational activities including injury/falls prevention programs. In addition, respondents recommended EOEA to focus on increasing home and health care workforce and establishing a single, coordinated system of information and access for all persons seeking long-term supports. For their communities, respondents recommended assisting elders with home modification, repair and maintenance services, and expanding options to help elder homeowners cope with the increase cost of homeownership.

VI. Discussion

The AAA planners conducted 206 single and multiple day events over a 15 -month period to garner input for their local area plans. Some 6,225 people participated in the events which included racial and language minorities, persons of Spanish/Latino heritage, low income, and persons with social needs or the vulnerable population (e.g., frail elders, isolated elders, rural elde rs, etc.) and their stakeholders. The statewide questionnaire which also targeted respondents under age 60 includes perspectives from 521 respondents who are primarily from the majority race, proficient in the English language, home owners, employed, careg ivers, and having incomes above the poverty level.

Although respondents from both methods deviate from the state's socio -demographic characteristic, priority areas and the concerns are very similar. As shown in Table D_1, the top three priority areas from the AAAs' events are highlighted in yellow (Health Care, Transportation and Financial Security) and expanded to include three additional priorities (shown in purple Maintain independence/Dignity and Family/Caregiving/ Support Network and Housing). Statew ide, Health Care, Financial Security and Maintain Independence/Dignity are the primary concerns followed by Family/Caregiving/Support Networks, Transportation and Housing .

Table D_1
Priority Area Rankings from AAA Planners' Events & Statewide Questionna ire

Priority Areas Voiced at 206 Events Sponsored by the AAAs					General Public Ranking				
Rank	Area	Priority (n=590)			Total	Under 60 Yrs	60 Yrs & Over	21 AAAs	1 AAA
		N	%	Cum %	n=513	n=208	N=305	n=399	n=111
1	Health care	103	17.5	34.9	1	2	1	1	1
1	Transportation	103	17.5		5	3	4	4	6
3	Financial security	83	14.1	49.0	2	5	2	3	2
4	Housing	71	12.0	61.0	6	7	6	6	5
5	Maintain independence/dignity	46	7.8	68.8	3	4	3	5	4
6	Family/caregiving/support networks	40	6.8	75.6	4	1	5	2	8
7	Food nutrition	30	5.1	80.7	10	8		8	
8	Safety and security	27	4.6	85.2			8	9	9
9	Long-term care	23	3.9	89.1	8	9	9	8	10
10	Leisure/recreation	20	3.4	92.5	9		7		3
11	Mental health	19	3.2	95.7	7	6	10	7	
12	Education/learning	14	2.4	98.1				10	
13	Legal assistance	6	1.0	99.1					
14	Volunteer/civic engagement	4	0.7	99.8					
15	Career/employment	1	0.2	100.0		10			7
16	Spirituality	0	0.0	100.0					

For statewide respondents under 60 years of age, Family/caregiving/support networks ranks first likely due to the large number also holding the role of informal caregivers. They are likely concerned about the health status and cost of health care for their care recipients as well as their own health. If accessible transportation is not available, then these respond ents likely assume escort/transportation responsibilities and undertake many errands for elders and disabled adults.

For the respondents from the single AAA, Health Care and Financial Security are also primary, but Leisure/Recreational activities are deemed important and Family/caregiving/support secondary. The ranking of priority areas by age group or geographical location shows that while the rank order may differ, the six areas are repeatedly cited by the respondents to enable elders and disabled adults to remain in their homes.

Regarding concerns/issues voiced at the AAA events or from the state questionnaire, Table D_2 shows the interconnectedness of one area to another. For example, issues, needs or concerns voiced about Financial Security are interconnected with Food and Nutrition, Health Care, Transportation, Housing, Mental Health, Family/Caregiving, Maintaining Independence, etc. (Cells with "P&S" indicate concerns/issues/needs voiced and garnered from both the AAA Planners' events and the statewide questionnaire. Cells with "P" and "S" indicate concerns/issues from the AAA Planners' events and statewide questionnaire, respectively.) Both data collection modes show the top six areas are highly interlinked with each other. In addition, participants at the AAA events voiced other issues/concerns connected with higher ranked areas in comparison to those garnered from the statewide survey.

Table D_2

Concerns Voiced from AAA Planners' and Public Survey Data Gathering Activities

Rank	Area	Health Care	Trans/per. mobility	Financial security	Housing/home ownership	Family/Crvg/SN	Maintain indp/dignity	Food & Nutrition	Long-term care	Safety/security	Mental health	Lesiure/recreation	Education/learning	Legal assistance	Vol./civic eng.	Career/emp	Spirituality
1	Health care		P&S	P&S		P&S	P&S	P&S	S	P&S	P&S	P	P&S	P			
1	Transportation/personal mobility	P&S		P&S	P	P&S	P&S	P	S	P&S	P	P&S	S		S		S
3	Financial security	P&S	P&S		P&S	P&S	P&S	P&S	S	P&S	P&S	P	S	S			
4	Housing/home ownership		P	P&S			P&S		P	P&S	P	P	S	P&S			
5	Family/caregiving/support	P&S	P&S	P&S			P&S		P&S	P&S	P&S	P&S	P&S	P&S			S
6	Maintain independence/dignity	P&S	P&S	P&S	P&S	P&S		P	P&S	P&S	P&S	S	S	P&S	S	S	S
7	Food and nutrition	P&S	P	P&S			P			S			P&S				
8	Long-term care	S	S	S	P	P&S	P&S				P&S	S	P&S	S			
9	Safety/security	P&S	P&S	P&S	P&S	P&S	P&S	S			S	S	S	S			
10	Mental health	P&S	P	P&S	P	P&S	P&S		P&S	S			P&S				
11	Lesiure/recreation	P	P&S	P	P	P&S	P&S		S	S						S	
12	Education/learning	P&S	S	S	S	P&S	S	P&S	P&S	S	P&S	S			S		S
13	Legal assistance	P		S	P&S	P&S	P&S		S	S							S
14	Volunteer/civic engagement		S				S						S				
15	Career/employment						S					S					
16	Spirituality		S			S	S						S	S			

Key:

P	AAA Planners (P)
P&S	AAA Planners & State (P&S)
S	State (S)

Safety and Security are being addressed in the communities. Almost universally offered across the municipalities are routine vaccinations against influenza and pneumococcal disease, meal services for elders, and referral services to locate general information about caregiver services. Over the past three years, call demands for EMS have been increasing in more than half of the communities (55%). In addition, in more than half of the communities, a registry or record of people who require additional assistance is maintained should a natural or man-made disaster occurs. Among the communities with a registry, slightly more than one-half of the communities have a single agency responsible for the registry and the remainder multiple agencies. The COAs hold a major role in maintaining and updating the registries that range from under 25 to over 900 people.

The communities play a key role in promoting individual wellness; 54% offer evidenced based prevention programs of which one addresses falls prevention. More than 9 of every 10 communities offer physical activity programs; the top five are aerobics, dancing, yoga and meditation, tai chi and walking. Among the 183 communities that offer physical activity programs, about 2 of every 5 have fitness equipment at their senior/community centers. The top five kinds of fitness equipment most in use include weights followed by resistance bands, treadmills, upright and/or recumbent bicycles, and elliptical machines.

Both statewide respondents and COA and senior center directors were asked to identify the top five service activities their communities and those for EOEA to focus on between now and 2013. (The comparisons are summarized in Tables D_3 and D_4.) The focus areas differ slightly between both groups. Municipalities report they plan to focus on promoting healthy aging (fitness/physical activities/falls prevention, preventative health care screening/immunization), social connections and volunteer/civic engagements, leisure and recreational activities, and public and paratransit transportation options. Although promoting leisure and recreational activities was not an item available for the statewide respondents, statewide respondents also concur with promoting healthy aging and public and paratransit transportation options. Divergence occurs hereafter as the statewide respondents indicate they would like their communities to focus on housing/home ownership assistance (i.e., assistance with home modification/repairs/maintenance, more affordable housing capacity, and assistance with housing expenses such as taxes/fees, utility, fuel, etc.) or items ranked 12, 11 and 9, respectively, by the municipalities. Promoting preventative health care screenings/immunizations which ranks 1st for the municipalities ranks 6th for the statewide respondents.

Both municipalities and the statewide respondents are more in concert for services EOEA to focus on between now and 2013 (Table D_4). They agree on improving/increasing public transportation options, promoting healthy aging, expanding affordable housing capacity and support options, and increasing home and health care workforce. Municipalities also recommend EOEA to expand the capacity of protective services and invest in outreach, while statewide respondents recommend establishing a single, coordinated information and access system.

When comparing municipalities' service areas of focus along with their recommended areas for EOEA to focus on along side the reported status of community preparedness in 20 service areas (Table D_5), joint efforts are revealed to address transportation options and promoting healthy aging (i.e., physical activities/fitness/fall prevention). Municipalities plan to focus on services less available across the communities (i.e., Health Care, Volunteer/Civic engagement, and Leisure and

recreation), and for EOEA to address three other areas (i.e., Housing/Home owne rship, Long-term Care and protective services that is classified under Safety and Security).

With regard to the home and health care workforce, an 18% turn -over-rate was found across 87 agencies that responded to the PQ. Providers reported their inabili ty to provide competitive wages and on-going need to recruit DCWs rendering increasing home and health care workforce a challenge. Working conditions are not ideal -- low wages, reimbursement for travel time or expenses are not uniformly consistent across providers, enrolling in health insurance are too costly for DCWs, and assignments are typically 1-2 hours resulting in less than full time work. While most of the providers will continue to operate as is, some providers plan within the next five years to i nclude their DCWs when reassessing client care plans, develop a career advancement program, and establish English competency for DCWs whose first language is not English.

VII. Summary

A three-level data collection approach was used for the 2009 Statew ide Needs Assessment Study. While data collection with consumers deviates somewhat from the Commonwealth's socio - demographic distribution, the information gathered from the four sources render information addressing EOHHS' and EOEA's initiatives as well as those identified by AoA.

Health care, financial security, transportation, family caregiving/support networks, housing/home ownership, and maintaining independence/dignity are the primary areas of elders' needs. Because issues/concerns voiced in an area are often linked to one or more areas of concern s, coordinating and managing the range of services are paramount for elders and their caregivers. For example, issues voiced under health care touch es affording prescriptions and paying medical bills, having access to physicians, managing and paying for medications, paying medical bills and proceeding with treatments, accessing sensory services especially dental and vision care, understanding one's health insurance plan to ensure coverage for assistive technolo gy and medical supplies, having access to transportation for medical appointments, finding an escort in some cases for a medical appointment, getting home safety checks for the prevention of accidental injuries and falls, hiring and managing home and health care workers, etc.

Accessible, reliable, flexible and affordable transportation services are repeatedly voiced by the respondents. So too is the need for more affordable housing and assistance with home ownerships expenses (i.e., mortgage/rent payment s, property taxes/fees, fuel assistance, utility expenses, home repairs and maintenance expenses) and home modifications. Consumer -directed care, also at the forefront for maintaining independence/dignity , remains a core service area of need to support elders to remain in their homes. Both municipalities and respondents voiced the need for more home and health care workers to support elders to remain in their homes and suggest a primary workforce development area for EOEA to address.

Regarding vulnerable target populations, services need to be made available especially for persons whose first language is not English, persons with mental illness, and LGBT adults. Statewide respondents indicated need for a single coordinated information and access system for all persons seeking long term supports. The ADRC model operating in three AAAs would likely address this need. In addition, statewide respondents under 60 voiced caregiver assistance and mental health services. While about half the communities promote heal thy aging activities, expanding the availability of physical fitness initiatives along with health screening and immunizations, fall s prevention programs, and leisure and recreational programs would be welcomed by both residents and communities.

Finally, with regard to Safety and Security, respondents from both the AAA events and statewide survey voiced their needs to learn about injury and accident prevention and to have well -maintained, unobstructed sidewalks with visible curb cuts, adequate street light ing for pedestrian safety, and better maintained public housing facilities. Call demands for EMS have been increasing in more than half the communities. Steps have been undertaken in more than a third of the communities with increased call demands for EMS. Also with regard to disaster preparedness, a registry or record of

people who require additional assistance is maintained in more than half of the communities. The COAs hold a major role in maintaining and updating the registry.

Table D_3

Service Areas Municipalities Will Focus Between Now and 2013
Comparison Between Municipalities & Statewide Respondents

Item #	Rank	Service Areas	Municipality N=209		Statewide Respondents (n=510) Total		< 60 (n=207)		≥ 60 (n-303)		21 AAA (n=399)		1 AAA (N=111)	
			N	%	Rnk	N	Rnk	N	Rnk	N	Rnk	N	Rnk	N
5	1	Promote health aging through physical activity/fitness/falls prevention.	166	79.4	5	182	5	64	5	118	5	140	5	42
3	2	Promote preventative health care, screenings and immunizations.	143	68.4	6	144	6	45	6	99	8	100	4	44
2	3	Promote social connections and volunteer/civic engagement in the community.	117	56.0	9	128	8	49	8	79	10	91	7	37
6	4	Promote leisure and recreational activities.	105	50.2										
10	5	Promote public and paratransit transportation options.	94	45.0	3	228	3	100	3	128	3	184	3	44
13	6	Improve our emergency response capacity for homebound and adult disabled residents.	69	33.0		59		21		38		50		9
14	7	Re-examine the role of senior centers in the community.	68	32.5	10	125	7	45	7	80	9	97	8	28
1	8	Help prepare residents for its aging population.	67	32.1	7	138	9	65	9	73	6	114	9	24
7	9	Help with increasing home ownership costs such as property taxes/fees and water/sewer/utility bills.	45	21.5	4	205	4	77	4	128	4	160	2	45
4	10	Improve access to mental health services along with screening, education and support programs.	39	18.7	8	130	10	72	10	58	7	109		21
9		Expand affordable elder housing capacity and support options.	34	16.3	2	256	2	127	2	129	2	217	6	39
8		Assist elders with home modification, repair and maintenance services.	27	12.9	1	290	1	123	1	167	1	228	1	62
15		Better planning to reflect residents' vision of "livable" community.	20	9.6		110		53		57		86		24
12		Encourage employment retention, training/retraining and recruitment of older workers.	8	3.8		85		27		58		66		19
11		Promote pedestrian and driver safety in community design and planning.	3	1.4		80		34		46		60		20
16		Other (write in)	18	8.6		18		9		9		14		4

Table D_4

Recommend Service Areas for EOEA to Focus Between Now and 2013
Comparison Between Municipalities and Statewide Respondents

Item #	Rank	Service Areas for ELD to Focus On	Municipality		Statewide Respondents									
			n=207		Total		< 60 (n=207)		≥ 60 (n-303)		21 AAA (n=399)		1 AAA (N=111)	
			N	%	Rnk	N	Rnk	N	Rnk	N	Rnk	N	Rnk	N
14	1	Improve access/increase public and paratransit transportation options.	105	50.7	2	228	2	100	3	128	2	179	2	49
11	2	Promote healthy aging through physical activities/fitness/falls prevention.	103	49.8	4	206	7	68	1	138	4	146	1	60
4	3	Expand affordable elder housing capacity and support options.	100	48.3	1	242	1	113	2	129	1	206	6	36
3	4	Increase home and health care workforce.	94	45.4	3	207	3	93	4	114	3	169	4	38
1	5	Expand capacity of protective services (abuse, fraud, exploitation, neglect and self-neglect) for elders.	91	44.0		92	8	45		47		78		14
7	5	Invest in outreach to targeted populations to raise their awareness of available services and supports.	91	44.0										
2	7	Improve access to mental health services including screenings and support programs.	87	42.0	7	150	4	84	9	66	6	129	10	21
13	8	Promote preventative health inc/screenings and immunizations.	68	32.9	8	145	9	42	5	103	8	99		13
15	9	Re-examine the role of senior centers.	60	29.0	9	112		35	8	77	9	87	8	25
10	10	Work with consumers and caregivers as well as providers and direct service workers to monitor service quality and effectiveness.	52	25.1										
5		Establish a single, coordinated information and access system for all persons seeking long-term supports.	49	23.7	5	173	6	71	6	102	5	136	5	37
6		Encourage residents to plan for their medical & non-medical LTC.	41	19.8	6	158	5	75	7	83	7	118	3	40
12		Educate residents about degenerative illnesses, specifically dementia/Alzheimer's Disease.	34	16.4		78		34		44		62		16
8		Promote financial well being.	24	11.6										
		Promote personal preparedness planning such as financial security and chronic disease self-management			10	106	9	42	10	64	10	79	7	27
9		Promote employment retention, training/retraining and recruitment of elders.	22	10.6		90		30		60		67	9	23
16		Other (write in)	6	2.9		40		19		21		34		6

Table D_5
Service Areas of Focus between Now and 2013

A1 Current	A2a Future	A2b EOEA	Rank Order	Areas to Support Elders to Remain Independent	N	Status (Percent) Exist	Dialogue	None
			1	9. Financial Security	198	**85.2**	4.1	10.7
			2	12. Legal Assistance	195	**76.3**	4.5	19.2
			3	6. Education/Learning	197	**74.5**	6.7	18.7
2	1	2	4	16. Physical Activity, Fitness & Falls Prevention	195	**74.2**	7.9	17.9
			5	2. Building/Zoning Codes	183	**73.0**	12.7	14.3
			6	4. Social Services	198	**72.9**	12.4	14.7
3			7	8. Food and Nutrition	197	**71.3**	7.8	20.9
			8	7. Family/Caregiving/Support Networks	198	**71.1**	9.3	19.6
	4		9	13. Leisure and Recreation	197	**65.4**	4.3	30.3
			10	1. Community Governance	197	**64.1**	20.4	15.5
	2		11	10. Health Care	197	**63.9**	3.7	32.4
		4	12	14. Long-term Care	197	**62.3**	9.2	28.5
			13	18. Spirituality	194	**57.6**	11.8	30.6
		5	14	17. Safety and Security	196	**54.5**	19.3	26.2
	3		15	20. Volunteer Opportunities/Civic Engagement	195	**53.9**	11.0	35.1
1	5	1	16	19. Transportation System	195	**50.1**	5.4	44.5
			17	3. Pedestrian and Driver Safety	193	**49.9**	15.2	34.9
		3	18	11. Housing and Home Ownership	197	**47.9**	13.4	38.7
			19	15. Mental Health	196	**46.9**	6.7	46.3
			20	5. Career/Employment Services	184	**21.0**	4.9	74.1

Appendix A
Survey Instruments

AAA Planners Needs Assessment Reporting Form
Providers' Questionnaire
Municipal Questionnaire
Survey of Elder Service Needs

2009 Needs Assessment Reporting Form

AAA_____Date:_____

Facilitator Name: _____Total Participants*_____

Location:_____ Start time: _____End time:_____

Vulnerable (target) population (Check applicable items):

Race: ___ Majority ___ Black ___ Native Am/PI ___ Asian ___ Multi-racial/Other
Ethnicity: ___ Spanish/Latino
Language: ___ Linguistic minority: specify_____
Economic need: ___ Low income elders ___Low income minority elders
Social need: ___ Rural elders ___ Frail elders ___ Caregiver support for elders ___ Isolated elders
___ Cognitive impairments ___ Nutrition-meals ___ Disabilities
___ Alzheimer's disease and other related disorders ___ Other: _____

Methodology/strategy (see key): _____

Issues vocalized/identified: From among all the concerns and issues voiced by participants, please use superscripts a, b, and c to identify the three major areas of concerns; superscripts 1, 2, and 3 to identify the top three issues voiced. (If more space is needed, use the back of this sheet.)

1.	11.
2.	12.
3.	13.
4.	14.
5.	15.
6.	16.
7.	17.
8.	18.
9.	19.
10.	20.

*If advocates/representatives, list organizations and number of elders being represented:

_____

_____

_____

Comments:
Revised May 2008

Areas of Concern for Living

AREA	Sub areas	Specific Needs within Area
Career/employment	Find employment Flexible job opportunities (job sharing) Retraining opportunities	Discounts to take classes
Education/learning	Educational programs Skill development	Learn to use emails, internet, and other electronic sites Skill development -- managing, navigating, coping, finding, etc.
Family/caregiving/support networks	Caregiver support Social/emotional support	Home care workers Personal care Respite care
Financial security	Apply/appeal financial assistance Maintain a livable standard of living Manage money/bills/claims	Debt/credit card bills Tax preparation
Food and nutrition	Nutrition education	Where to get nutrition information
Health care	Dental care Hearing care Physical or sensory disability Prescription drugs Substance and tobacco abuse Vision care	Alcohol abuse Drug abuse Smoking cessation Eye glasses Stroke, diabetes, coronary etc
Housing and home ownership	Alternative senior housing Home owner matters Renter/tenant matters Utility bills	Mortgage payments, property taxes, relief, repairs, snow removal, yard maintenance, weatherization Rental payment, rights Heating bills
Legal assistance	Legal counsel Advocate/support person	Immigration/naturalization Estate planning and wills Assistance in getting services
Leisure, recreation, and fitness	Dating opportunity Join interest groups/clubs Social gathering activities Fitness/athletic programs	Go to the casino Take day or long distance trips
Long-term care	Types of long term care options	Homemaker/chore services
Maintain independence/dignity	Estate planning/wills Immigration/naturalization Insurance issues Palliative or end-of-life care	
Mental health	Access to mental health services	Depression
Safety and security	Abuse, neglect, fraud and exploitation Self neglect	Consumer complaints Identity theft
Spirituality	Religious activities Other spiritual activities	
Transportation	Escort service Public transportation	Keep medical appointment Attend social activities Do basic errands
Volunteer/civic engagement	Opportunities to volunteer	
Other		

Methodologies for Conducting Needs Assessment Study

Methodology	Techniques
Conferences including video	Expo Summit
Experts	Issue papers Panels Retreat Task force
Interviews	One-on-one – Person-to-person, telephone Group – Video, conference calls
Large public gathering	Community meeting/forum Graffiti Wall Listening session Mapmaking Public event (street/service fair) Public hearing Public forum
Public Comments	Town meeting Regional meeting
Secondary data (No reporting form needs to be submitted for secondary data activities.)	AGing Integrated Database Higher education institutions KnowledgePlex Legislative reports Local Planning Office Municipal and state agencies Position papers Prior Studies U.S. Census or AoA
Small public gathering (under 15)	Coffee (beverage) hour Focus groups
Stakeholders	Advisory groups/associations/councils Advocacy groups/associations Community leaders
Surveys	Mail Telephone Web
Taskforce	AAA network Leadership groups Institutes Stake holder's retreat
Other	

PROVIDERS' QUESTIONNAIRE
2009 Needs Assessment Study

Name of Provider: _____ Phone #: _____

Title of person completing the questionnaire: _____

Email Address: _____ Website Address: _____

Service Regions (check applicable regions): ___Cape and the Islands ___Central MA

___Greater Boston ___Metrowest ___North Shore ___South Shore ___Western MA

Agency Services (check applicable items):

___Adult Day Health ___Adult Foster Care ___Chore ___Companion
___Dementia Day Care ___Emergency Shelter ___Home Health Aide ___Homemaker
___Personal Care ___Supportive Day Care ___Other (write in) _____

A. AGENCY STAFFING PATTERN

For this questionnaire, direct care workers (DCWs) refer to non -licensed employees who assist clients directly with ADL, IADL or both, and hold job titles such as home health aide, homemaker, personal care homemaker, and supportive home care aide. Please indicate:

1. Total (all) number of employees in your agency: _ # of FT DCWs:_____ # of PT DCWs:_____

2. # of DCWs who left your agency in the last 12 months: __ Your annual DCWs' turn over rate: ___%

3. Range of employment years and average years of employment among your DCWs. Please round to nearest month (e.g., 3 years 9 months is 3.9 years).

   Range: Newest DCW _____ Most senior DCW _____

   Average Employment Years Among DCWs: _____

B. TRAINING

The following are mandatory annual home care aide trainings for direct care workers:

- *Universal Precautions*
- *Elder Abuse and Neglect and the MA Patient Abuse Statute*
- *Safety Policies including Patients' Right, Back Safety, Home Safety and Emergency Procedures*

In addition to the above, what other trainings have your DCWs requested or your agency required DCWs to attend on an annual basis? If none, please write 'None'.

Training Title	Primary Topic (e.g., depression)	Title of Direct Care Employees	# of Training Hours	Certificate Issued Yes	Certificate Issued No
1.					
2.					
3.					

C. CHALLENGES

3. In next five years (2009-2013), how likely is it that your agency will focus on the following items particularly with regard to employing DCWs?

   For each item, two responses are requested. First, under the column "**CP"** or Current Practice, check Y (Yes) or N (No) if your agency is currently engaged in the practice. Second , indicate how likely your agency will undertake or will continue to engage in the activity using the following five - point scale:

   VL=Very Likely **L=**Likely **NC=**No change **U**=Unlikely **VU**=Very Unlikely

CP		My agency will focus on…	VL	L	NC	U	VU
Y	N						
		A. Increasing or providing competitive wage compensation.					
		B. Providing job security.					
		C. Reducing the numbers of on-the-job injuries or safety.					
		D. Offering health insurance that DCWs can pick up and afford.					
		E. Recruiting qualified/skilled DCWs.					
		F. Serving non-English speaking and culturally diverse populations.					
		G. Serving elders in rural or remote areas.					
		H. Providing compensation for travel time/transportation expenses.					
		I. Reducing the DCWs' turn-over rate.					
		J. Ensuring English language competency for DCWs whose first language is not English.					
		K. Developing a career advancement program for DCWs.					
		L. Improving the job image of DCWs.					
		M. Including DCWs when reassessing clients' care plans.					
		N. Improving supervision/management practices for DCWs.					
		O. Ascertaining clients' satisfaction with our direct care services.					

2. Please list the **major challenge** you or those in your industry are currently facing with regard to the direct care workforce. Please also provide your suggestion(s) to help resolve your cited challenge.

Comments:

2009 Needs Assessment Survey--Municipal Questionnaire

In preparation for the 2010-2013 State Plan on Aging, the Executive Office of Elder Affairs is interested in learning how municipalities are preparing for the advent of the baby boomers. We seek your assistance in helping us better understand your service priorities, service delivery challenges, program deve lopment needs as well as your municipality's capacity and readiness to address the rapidly growing senior population. In this endeavor, please fill out this questionnaire, which contains three parts.

Part A seeks information about the top three priority areas your agency is currently focused on to support elders and adults with disabilities. In addition, inquiries are made about service delivery challenges your municipality will likely focus on and about which you would recommend Elder Affairs to focus on between now and 2013.

Part B requests program information regarding safety and security, and evidenced based programs pertaining to injury/fall prevention and physical activities. (In some cases, you may need to consult another municipal office for the requested information.)

Part C seeks to learn the status of your community's preparedness for the coming shift in the demographics and service needs of elders.

The questionnaire will take about 20 to 30 minutes to complete. You do **not** need to complete the survey all at once! For example, you can take 10-15 minutes on two separate days to complete the questionnaire (e.g., complete Parts A and B on Monday and Part C on Wednesday). As long as you **use the same computer**, you will be able to return to the questionnaire, as well as change your responses, until the closing date (October20, 2008) of the survey administration.

All responses will be kept strictly confidential. Results will be reported in the aggregate, and posted on Elder Affairs' web site in Spring 2009.

Thank you in advance for your consideration and partnership in this effort.

****

Municipal Identifier:
Please use the blank space to write your answers.

Name of municipality:	_____
Name of person completing the questionnaire:	_____
Position title:	_____

My Area Agency on Aging is:
Please pick one of the answers below.

[ ] BayPath Elder Services, Inc.
[ ] Bristol Elder Services
[ ] Central Mass Agency on Aging, Inc.
[ ] Chelsea/Revere/Winthrop Home Care Center, Inc.
[ ] Coastline Elder Services, Inc.
[ ] Commission on Affairs of the Elderly
[ ] Elder Services of Berkshire County, Inc.
[ ] Elder Services of Cape Cod and the Islands, Inc.
[ ] Elder Services of Merrimack Valley, Inc.
[ ] Franklin County Home Care Corporation
[ ] Greater Lynn Senior Services, Inc.
[ ] Greater Springfield Senior Services, Inc.
[ ] Health & Social Services Consortium, Inc. (HESSCO)
[ ] Highland Valley Elder Services, Inc.
[ ] Minuteman Senior Services, Inc.
[ ] Mystic Valley Elder Services, Inc.
[ ] North Shore Elder Services, Inc.
[ ] Old Colony Planning Council
[ ] SeniorCare, Inc.
[ ] Somerville-Cambridge Elder Services, Inc.
[ ] South Shore Elder Services, Inc.
[ ] Springwell
[ ] WestMass ElderCare, Inc.

The current estimated total elder population (60 years and over) in my community is...
Please pick one of the answers below.

[ ] Under 500
[ ] 500 - 999
[ ] 1,000 - 2,499
[ ] 2,500 - 4,999
[ ] 5,000 - 7,499
[ ] 7,500 - 9,999
[ ] 10,000 - 24,999
[ ] 25,000 - 49,999
[ ] 50,000 and over

Part A. Service Priorities for Elders

1. Current Service Priorities

Sixteen service areas for elders are listed alphabetically. Please indicate the **top three areas your community** is currently providing to support elders. If a priority area is not listed, please add under "Other."

Please check all that apply and/or add your own variant.

[ ] Career/employment
[ ] Education/learning
[ ] Family/caregiving/support network
[ ] Financial security (money/finances)
[ ] Food and nutrition
[ ] Health care
[ ] Housing and home ownership
[ ] Legal assistance
[ ] Leisure and recreational activities
[ ] Long-term care
[ ] Mental health
[ ] Physical activity/fitness/falls prevention
[ ] Safety and security (public and personal)
[ ] Spirituality
[ ] Transportation/personal mobility
[ ] Volunteer/civic engagement
[ ] Other (write in)

2. Service Delivery Initiatives

a. From among the initiatives listed, please indicate up to FIVE that **your community** will (continue to) focus on for elders between now and 2013. If an initiative is not listed, please add under "Other."

Please check all that apply and/or add your own variant.

[ ] Help prepare residents for its aging population.
[ ] Promote social connections and volunteer/civic engagement in the community.
[ ] Promote preventative health care, screenings and immunizations.
[ ] Improve access to mental health services along with screening, education and support programs.
[ ] Promote health aging through physical activity/fitness/falls prevention.
[ ] Promote leisure and recreational activities.
[ ] Help with increasing home ownership costs such as property taxes/fees and water/sewer/utility bills.
[ ] Assist elders with home modification, repair and maintenance services.
[ ] Expand affordable elder housing capacity and support options.
[ ] Promote public and paratransit transportation options.
[ ] Promote pedestrian and driver safety in community design and planning.
[ ] Encourage employment retention, training/retraining and recruitment of older workers.
[ ] Improve our emergency response capacity for homebound and adult disabled residents.
[ ] Re-examine the role of senior centers in the community.
[ ] Better planning to reflect residents' vision of "livable" community.

[ ] Other (write in)

b. From among the initiatives listed, indicate up to FIVE that you would **recommend Elder Affairs to focus on** between now and 2013. If an initiative is not listed, please write it in under "Other."

Please check all that apply and/or add your own variant.

[ ] Expand capacity of protective services (abuse, fraud, exploitation, neglect a nd self-neglect) for elders.
[ ] Improve access to mental health services including screenings and support programs.
[ ] Increase home and health care workforce.
[ ] Expand affordable elder housing capacity and support options.
[ ] Establish a single, coordinated information and access system for all persons seeking long term supports.
[ ] Encourage residents to plan for their medical and non -medical long term care.
[ ] Invest in outreach to targeted populations to raise their awareness of available s ervices and supports.
[ ] Promote financial well being.
[ ] Promote employment retention, training/retraining and recruitment of elders.
[ ] Work with consumers and caregivers as well as providers and direct service workers to monitor service quality and effectiveness.
[ ] Promote healthy aging through physical activities/fitness/falls prevention.
[ ] Educate residents about degenerative illnesses, specifically dementia/Alzheimer's Disease.
[ ] Promote preventative health including screenings and immu nizations.
[ ] Improve access/increase public and paratransit transportation options.
[ ] Re-examine the role of senior centers.
[ ] Other (write in)

Part B. Safety and Security

1. Emergency Medical Services (EMS)

a. Reviewing your EMS service call s for calendar years 2005, 2006 and 2007, have the numbers of service calls for elder residents decreased, remained stable or increased? The EMS service calls have:

Please pick one of the answers below.

[ ] Decreased (If this response, respondent goes to c.)
[ ] Remained stable (If this response, respondent goes to c.)
[ ] Increased (If this response, respondent continues to b.)

b. Please indicate your community's average rate of increase across the three calendar years?

Please pick one of the answers below.

[ ] Less than 5%
[ ] Between 5% to 10%
[ ] Between 10% to 15%
[ ] Between 15% to 20%
[ ] 20% or greater

c. Are there any programs, services or regulations being considered by your community to address an anticipated or the increasing trend for EMS service calls?

Please pick one of the answers below.

[ ] Yes (If this response, respondent goes to d.)
[ ] No (If this response, respondent goes to question 2.)
[ ] Unsure (If this response, respondent goes to question 2.)

d. Please provide the name and a brief description of your initiative. Please write your answer in the space below.

2. Emergency Management Planning

a. Should a natural or man-made disaster/threat occur in your community, does your municipalit y maintain a registry or record of people who require additional assistance to respond to emergencies?

Please pick one of the answers below.

[ ] Yes (If this response, respondent continues to 2.a.1.)
[ ] No (If this response, respondent goes to question 3.)
[ ] Unsure (If this response, respondent goes to question 3.)

(1) Please tell us the name of the department(s) that is/are responsible for maintaining and updating the registry information? Please write your answer in the space below.

(2) How many people who require additional assistance (e.g., homebound people, elders and adults with disabilities) are currently "registered" with your community?

Please pick one of the answers below or add your own.

[ ] Less than 25
[ ] 25 to 50
[ ] 50 to 75
[ ] 75 to 100
[ ] 100 to 150
[ ] 150 to 200
[ ] 200 to 300
[ ] 300 and more
[ ] Other

3. Evidenced-based Prevention Programs

As defined by the Administration on Aging, "evidence based prevention programs are interventions … that have been proven effective in reducing the risk of disease, disability, and injury among elderly. " For example:

Chronic Disease Self Management Program
Healthy Eating for Successful Living in Older Adults
A Matter of Balance (fall prevention)

a. How many unique (unduplicated) evidence-based programs to reduce the risk of disease, disability and injury among elders have been conducted in your community in the last 12 months?

Please pick one of the answers below.

[ ] None If None, respondent goes to question 4.
[ ] 1-2 If GE 1, respondent continues to b.
[ ] 3-5
[ ] 6-10
[ ] 11-15
[ ] 16-20

[ ] 21-25
[ ] More than 25

b. Among the evidenced-based programs, how many were specifically designed for FALL PREVENTION? Please pick one of the answers below or add your own.

[ ] None — If None, respondent goes to question 4.
[ ] 1 — If 1 or more, respondent continues to c.
[ ] 2
[ ] 3
[ ] 4
[ ] 5
[ ] If more than 5, indicate number:

c. Please list each evidenced-based fall prevention program:

4. Strength, Flexibility and Cardiovascular Activities

According to the Centers of Disease Control and Prevention (CDC), regular physical activity is participation in three or more 20-minute sessions activity that makes the person sweat or five or more 30 minute sessions of slower activity such as walking.

Does your community sponsor or offer physical activity programs?
Please pick one of the answers below.

[ ] Yes — (If yes, respondent continues with a.)
[ ] No — (If no, respondent goes to Part C.)

a. Some examples of physical activities sponsored by your community or with funds from Elder Affairs follows:

Aerobics with weight training
Chair aerobics; sit and stretch
Line dancing
Low-impact aerobics
Osteo prevention
Pilates
T'ai chi
Strength/weight training
Strength/weight training for frail elders
Walk club
Water aerobics
Wii
Yoga
Zumba or Zumba Gold

Reviewing your records for the past 12-18 months, please cite the FIVE most popular types of physical activities elders engaged in by descending order of participation. Please use the blank space to write your answers.

Physical activity with highest number of participation	_____
Physical activity with second highest number of participation	_____

Physical activity with third highest number of participation	_____
Physical activity with fourth highest number of participation	_____
Physical activity with fifth highest number of participation	_____

b.1 Do you have fitness equipment at your center?

Please pick one of the answers below.

[ ] Yes (If yes, respondent continues to b.2.)

[ ] No (If no, respondent goes to Part C.)

b.2 Please list in descending order, th e fitness equipment most in use. For example:

Back extension machine
Elliptical machine
Free weights
Resistance bands
Treadmill
Upright and/or recumbent bicycles

Please use the blank space to write your answers.

Fitness equipment most in use _____
Fitness equipment second most in use _____
Fitness equipment third most in use _____
Fitness equipment fourth most in use _____
Fitness equipment fifth most in use _____

Part C. Community Preparedness

We seek to ascertain the "aging readiness" of communities. The following areas are generated from livable communities and aging in place literature.

1. Community Governance
2. Building/Zoning Codes
3. Pedestrian and Driver Safety
4. Social Services
5. Career/Employment Services
6. Education/Learning
7. Family/Caregiving/Support Networks
8. Food and Nutrition
9. Financial Security
10. Health Care
11. Housing and Home Ownership
12. Legal Assistance
13. Leisure and Recreation
14. Long-term Care
15. Mental Health
16. Physical Activity, Fitness and Falls Prevention
17. Safety and Security
18. Spirituality
19. Transportation System
20. Volunteer Opportunities/Civic Engagement

An inventory of activities or practices is listed under each area. Please indicate the status of each activity or practice in your community based on the following:

Exists = The activity/practice exists in my community.

Dialogue = Although the activity/practice does not exist in my community, a dialogue is occurring.
None = The activity/practice does not occur in my community.
N/A = The activity/practice does not apply to my community.

1. Community Governance: My community has...

Please mark the corresponding circle - only one per line.	Exists	Dialogue	None	N/A
1) A community action plan which includes the needs of older adults and recommendation to help meet these needs.	O	O	O	O
2) A COA director recognized as a municipal department head.	O	O	O	O
3) Coordination of projects between local government and local AAA as well as other social services agencies or organization.	O	O	O	O
4) Established connections and communication between other the COA and community resources.	O	O	O	O
5) Established connections and communication between the COA and other municipal departments.	O	O	O	O
6) Information about the COA on the website.	O	O	O	O
7) Official municipal policies specifying the importance of including elders and their concerns in all program development and decision-making processes.	O	O	O	O
8) Plans to ensure all land use patterns, transportation routes, and community facilities meet the needs of an aging society.	O	O	O	O
9) Regular opportunities for public input into municipal plans and actions affecting elders.	O	O	O	O

2. Building/Zoning Codes: My community has...

Please mark the corresponding circle - only one per line.	Exists	Dialogue	None	N/A
1) Building codes that require "universal design" (e.g., construction of wheelchair ramps, doorway size of at least 32" wide with swing clear hinges, location of electrical outlets 18" -48" above the floor, hallway widths at least 42", etc.).	O	O	O	O
2) Zoning codes that allow accessory dwelling units.	O	O	O	O
3) Zoning codes that allow mixed use and pedestrian - friendly development in appropriate areas (such as town center).	O	O	O	O
4) Zoning codes that allow multifamily housing.	O	O	O	O
5) Zoning codes that support the development of assisted living facilities.	O	O	O	O

3. Pedestrian and Driver Safety: My community has...

Please mark the corresponding circle - only one per line.	Exists	Dialogue	None	N/A
1) A walkability plan.	O	O	O	O
2) Adequate lighting along sidewalks for pedestrians to be and feel safe.	O	O	O	O
3) Benches at regular intervals along "pedestrian routes" to allow people with physical limitations to rest.	O	O	O	O
4) Locations where indoor walking can take place (e.g., shopping malls) which are open for community walkers.	O	O	O	O
5) Mid-block crosswalks or pedestrian traffic signals on long streets with no intersections.	O	O	O	O
6) Street crossings made safe and accessible (e.g., bump -outs, crosswalk countdown, island in middle of the street, etc.).	O	O	O	O
7) Well-maintained, unobstructed sidewalks with visible curb cuts.	O	O	O	O
8) Road design tailored to the needs of older adult drivers	O	O	O	O

(e.g., larger signage, left turn lanes, road markings, etc.).

4. Social Services: My community has...

Please mark the corresponding circle - only one per line.	Exists	Dialogue	None	N/A
1) A single entry point or one-stop-shop for elder resources and services.	O	O	O	O
2 A directory of services available to elders in need.	O	O	O	O
3) A central phone number that people can call when they need assistance but do not know where to turn.	O	O	O	O
4) A follow-up process to make sure people got connected with the appropriate group or organization.	O	O	O	O
5) A service that provides people to run errands for elders.	O	O	O	O

5. Career/Workforce Development: My community has...

Please mark the corresponding circle - only one per line.	Exists	Dialogue	None	N/A
1) An employment placement service with staff skilled in placing seniors.	O	O	O	O
2) Job banks for older adults.	O	O	O	O
3) Job retraining opportunities.	O	O	O	O
4) The Career Center/One Stop.	O	O	O	O
5) The Senior Community Service Employment Program.	O	O	O	O

6. Education/Learning: My community has...

Please mark the corresponding circle - only one per line.	Exists	Dialogue	None	N/A
1) A library program to deliver books (electronically connect) to people who are homebound.	O	O	O	O
2) Bilingual classes for non-English speaking older adults.	O	O	O	O
3) Community sponsored events that promote culture such as conce rts, shows, celebrations, etc.	O	O	O	O
4) Community sponsored events that promote fine arts and crafts such as water color, knitting, quilting, needlepoint, etc.	O	O	O	O
5) Discounts for elders who want to ta ke classes at local colleges or universities.	O	O	O	O
6) Information programs on topics of interest to elders offered at community centers or other public facilities.	O	O	O	O
7) Library information programs such as bo ok discussions and speakers on topics of interest to elders.	O	O	O	O
8) Low-cost programs to teach elders how to use the computer (e.g., navigation and research skills).	O	O	O	O

7. Family/Caregiving/Support Networks: My community has...

Please mark the corresponding circle - only one per line.	Exists	Dialogue	None	N/A
1) Referral services to locate general information about caregiver services.	O	O	O	O
2) Caregiver education programs.	O	O	O	O
3) Caregiver support groups.	O	O	O	O
4) Caregiver respite services.	O	O	O	O
5) Caregiver counseling services.	O	O	O	O

8. Food and Nutrition: My community has...

Please mark the corresponding circle - only one per line.	Exists	Dialogue	None	N/A
1) A farmers' market or other means of access to fresh food.	O	O	O	O
2) Assistance in meal preparation (e.g., how to prepare healthy meals and snacks).	O	O	O	O
3) Meal services for elders (e.g., home delivered meals, congregate meal sites, transportation to meal sites).	O	O	O	O
4) Places to minimizing hunger/food insecurity (e.g., identifying places to buy affordable food; local food banks or pantries).	O	O	O	O
5) Nutrition education classes specifically for elders and adults with disabilities.	O	O	O	O

9. Financial Security (money and finances): My community provides...

Please mark the corresponding circle - only one per line.	Exists	Dialogue	None	N/A
1) Assistance with basic needs such as a food or clothing pantry.	O	O	O	O
2) Discount options for transportation services.	O	O	O	O
3) Education and information about financial fraud and predatory lending.	O	O	O	O
4) Financial assistance for residents in emergency situations.	O	O	O	O
5) Fuel oil or other financial assistance for heating.	O	O	O	O
6) Property tax relief for elders with limited incomes.	O	O	O	O
7) Assistance for elders in preparing and filing taxes.	O	O	O	O

10. Health Care: My community has/hold...

Please mark the corresponding circle - only one per line.	Exists	Dialogue	None	N/A
1) A hospital or medical center in the community.	O	O	O	O
2) A minor emergency care center such as a walk-in clinic in the community.	O	O	O	O
3) A pharmacy that is accessible 24 hours a day/seven days a week.	O	O	O	O
4) An emergency room in the community.	O	O	O	O
5) At least one dentist per 2,500 residents serving residents (of all ages).	O	O	O	O
6) At least one primary care physician per 1,000 residents (of all ages).	O	O	O	O
7) Chronic disease self-management educational programs.	O	O	O	O
8) Diagnostic services such as x-ray, hearing, and vision in the community.	O	O	O	O
9) Free preventive screenings such as mammogram, hearing, vision, PSA, bone density and blood pressure checks.	O	O	O	O
10) Medication management services or programs.	O	O	O	O
11) Preventative immunizations such as influenza and pneumonia.	O	O	O	O
12) Health education programs on topics important to elders.	O	O	O	O
13) Health fairs that provide information and screenings for seniors on a regular basis.	O	O	O	O

11. Housing and Home Ownership: My community has...

Please mark the corresponding circle - only one per line.	Exists	Dialogue	None	N/A
1) A community housing assessment completed in the past three years that projects future housing needs for various populations.	O	O	O	O
2) A program or service to assist community members of limited means with interior and exterior modifications to homes.	O	O	O	O
3) A service to mediate between elders and contractors when there are problems.	O	O	O	O
4) An adequate number of licensed contractors who do interior and exterior modifications to home (e.g., grab bars, ramps).	O	O	O	O
5) Assessments to help elders identify opportunities to modify their homes for better function and safety.	O	O	O	O

6) Assistance in home weatherization.	O	O	O	O
7) Modification of municipal services for elders such as backyard trash collection.	O	O	O	O
8) Subsidized housing facilities.	O	O	O	O

12. Legal Assistance: My community has...

Please mark the corresponding circle - only one per line.	Exists	Dialogue	None	N/A
1) Low or no-cost legal services specializing in the needs of elders.	O	O	O	O
2) Assistance for elders in preparing legal documents including wills, trusts, advance care plans, power of attorney.	O	O	O	O
3) Programs or seminars on legal issues of interest to elders.	O	O	O	O

13. Leisure and Recreational Activities: My community has...

Please mark the corresponding circle - only one per line.	Exists	Dialogue	None	N/A
1) A café society site for elders.	O	O	O	O
2) An inventory of parks/recreation/sports opportunities complied for the community and available to the public.	O	O	O	O
3) Community-sponsored events that promote social interactions such as drop in centers, picnics, etc.	O	O	O	O
4) Cultural opportunities that reflect the ethnic demographics of your community.	O	O	O	O
5) Discounted elder prices at local attractions.	O	O	O	O
6) A swimming pool.	O	O	O	O
7) Bicycling trails.	O	O	O	O
8) Community gardening.	O	O	O	O
9) Golf courses.	O	O	O	O
10) Indoor/outdoor courts for games such as tennis, basketball, racket ball, etc.	O	O	O	O
11) Outdoor recreational facilities for boating, canoeing, fishing, etc.	O	O	O	O
12) Parks and other exercise venues accessible through several modes of mobility.	O	O	O	O
13) A facility built or renovated specifically for elders to participate in leisure and recreational activities.	O	O	O	O

14. Long-term care: My community has/provides...

Please mark the corresponding circle - only one per line.	Exists	Dialogue	None	N/A
1) Informational sessions about planning for long-term care.	O	O	O	O
2) Adult day services or other facilities designed especially for those with dementia or Alzheimer's Disease.	O	O	O	O
3) Hospice care.	O	O	O	O
4) Consumer-directed models of care, i.e. consumers determine what types of services they will receive and the manner in which they receive them.	O	O	O	O
5) Long-term care options in housing facilities or in the elder's home.	O	O	O	O
6) Coordination of care services (e.g., case managers) to enable elders to remain in their homes.	O	O	O	O
7) Routine podiatry screenings especially for people with diabetes.	O	O	O	O
8) Routine vaccinations against influenza and pneumococcal disease.	O	O	O	O
9) Consumers/residents access to long-term care and supports through a single agency.	O	O	O	O
10) Programs to reduce the prevalence of obesity among older adults.	O	O	O	O

11) Programs to reduce chronic lower respiratory diseases.	O	O	O	O

15. Mental Health: My community has...

Please mark the corresponding circle - only one per line.	Exists	Dialogue	None	N/A
1) Alcohol and substance abuse treatment services in the community.	O	O	O	O
2) In-patient psychiatric services in the community.	O	O	O	O
3) Linkages between mental health and primary care organizations.	O	O	O	O
4) Mental health counselors specializing in geriatric mental health.	O	O	O	O
5) Mental health counselors with expertise in providing services to cultural and linguistic minorities.	O	O	O	O
6) Out-patient mental health counselors available to residents.	O	O	O	O
7) Programs available for elders on depression.	O	O	O	O
8) Programs available for elders on grief and bereavement.	O	O	O	O

16. Physical Activity, Fitness and Falls Prevention: My community has...

Please mark the corresponding circle - only one per line.	Exists	Dialogue	None	N/A
1) Exercise and wellness programs specifically tailored to elders.	O	O	O	O
2) Community-sponsored events that promote physical activity such as public walks, biking events, etc.	O	O	O	O
3) Parks and other exercise venues accessible through several model of mobility.	O	O	O	O
4) A program that actively focuses on preventing falls and other injuries.	O	O	O	O
5) Walking and jogging trails.	O	O	O	O

17. Safety and Security: My community has...

Please mark the corresponding circle - only one per line.	Exists	Dialogue	None	N/A
1) A program to educate the public about personal safety and security.	O	O	O	O
2) A program to provide emergency cell phones to elders who need them.	O	O	O	O
3) A service for checking up on elders living alone by t elephone.	O	O	O	O
4) A system for elder abuse/neglect/fraud identification and prevention.	O	O	O	O
5) Free, in-home safety checks for elders.	O	O	O	O
6) Neighborhood watch programs.	O	O	O	O
7) Plans for evacuation of homebound persons or elders in the event of a natural disaster or homeland security threat.	O	O	O	O
8) Smoke detectors and batteries offered free for elders, including installation.	O	O	O	O
9) Training for law enforcement, fire department and EMT personnel on how to be sensitive to needs of elders.	O	O	O	O

18. Spirituality: My community has...

Please mark the corresponding circle - only one per line.	Exists	Dialogue	None	N/A
1) Faith-based organizations active in helping elders, such as family counseling, preventing isolation, etc.	O	O	O	O
2) Faith-based organizations that provide transportation to services and activities.	O	O	O	O
3) Faith-based organizations with activities specifically for their elder	O	O	O	O

members.				
4) Faith-based organizations that support and participate in the senior care network.	O	O	O	O

19. Transportation System: My community has...

Please mark the corresponding circle - only one per line.	Exists	Dialogue	None	N/A
1) A public transportation system or coverage by a regional transportation authority.	O	O	O	O
2) Clearly-marked public transportation stops.	O	O	O	O
3) Dial-a-ride and door-to-door paratransit options.	O	O	O	O
4) Discounted taxi cab fares for elders.	O	O	O	O
5) Easy-to-obtain, easily-legible information on public transportation routes and schedules available in multiple languages.	O	O	O	O
6) Nearby access to out-of-town travel options such as air, bus, and train.	O	O	O	O
7) Public transportation on holidays/weekends.	O	O	O	O
8) Public transportation to major shopping/service areas, senior centers, adult day services, faith communities, and cultural events.	O	O	O	O
9) Shelters, places to sit, and lighting at most public transportation stops.	O	O	O	O
10) A comprehensive land-use plan coordinated with transportation planning.	O	O	O	O

20. Volunteer Opportunities/Civic Engagement: My community has...

Please mark the corresponding circle - only one per line.	Exists	Dialogue	None	N/A
1) A leadership development program for elders that helps them learn skills and tools to enable them to participate more effectively as leaders in the community.	O	O	O	O
2) A program or clearinghouse to help elders identify volunteer opportunities.	O	O	O	O
3) A range of opportunities for elders who want to volunteer.	O	O	O	O
4) A Service Corps of Retired Executives (SCORE) program.	O	O	O	O
5) Intergenerational volunteer opportunities.	O	O	O	O
6) Opportunities for older adults to serve as mentors or share their expertise.	O	O	O	O
7) Transportation to the polls for elders on Election Day.	O	O	O	O

Please provide any additional comments regarding how your community is preparing for the rapidly growing senior population. Please write your answer in the space below.

Survey of Elder Service Needs

Welcome!

The Massachusetts Executive Office of Elder Affairs (Elder Affairs) is interested in learning about service needs for people 60 years and over, adults with disabilities and caregivers. The results from this questionnaire will be used to dev elop Massachusetts 2010-2013 State Plan on Aging, that is, our aging plan for programs and services that we submit to the U.S. Administration on Aging to receive federal funds under the Older Americans Act.

We invite all adults to respond to this survey. The survey should take between 5 and 7 minutes to complete. All responses will be kept strictly confidential. All responses will be summarized and reported in the aggregate, and posted on Elder Affairs' web site in Spring 2009.

Thank you for your participation.

Before getting started, would you kindly tell us how you first learned about this survey? Check all that apply.

Please check all that apply and/or add your own variant.
___ Area Agency on Aging (AAA)
___ Aging Services Access Points (ASAPs)/Ho me Care Corporations
___ Council on Aging/Senior Center
___ State Human Resources Network (pay advice)
___ Local radio or cable TV station
___ Newsletter or local paper
___ Membership notification from an organization/association
___ Colleague, friend or family member
___ Home care or personal care attendant
___ Attendance at a meeting or event
___ Do not recall
___ Other (write in)_____

Part I — Service Needs

Sixteen areas of need are listed and are based on previously administered surveys completed by elders. Would you kindly tell us in which areas you need assistance? Please indicate **up to three areas** and by **priority order**.

For example, a person's three need areas are MENTAL HEALTH followed by HOUSING then FITNESS. Indicate "1" next to Mental health, "2" next to Housing and home ownership, and "3" next to Leisure, recreation and fitness.

If you **do not need assistance** in any area, Go To page 10, Part II — Service Areas of Focus.

_____Career/employment
_____Education/learning
_____Family/caregiving/support networks
_____Financial security (money/finances)
_____Food and nutrition
_____Health care
_____Housing and home ownership
_____Legal assistance
_____Leisure, recreation and fitness
_____Long term care
_____Maintain independence and dignity
_____Mental health
_____Safety and security
_____Spirituality
_____Transportation/personal mobility
_____Volunteer/civic engagement

On pages 3-9, there are items listed under each of the 16 areas. **Answer ONLY the items corresponding to your one, two or three areas indicated above. Skip all other areas.** After responding to the items under your area(s), **Go To** page 10, Part II — Service Areas of Focus.

Regarding "**career/employment**" my specific needs include: (Check all that apply.)
___ securing full time employment.
___ securing part-time employment.
___ enrolling in a training or vocational rehabilitation program.
___ finding the Career Center/One Stop in my community.
___ participating in the Senior Community Service Employment Program.
___ securing employment counseling and guidance.
___ accessing services through the computer.
___ planning for retirement.
___ talking with someone about my rights under the federal laws prohibiting job discrimination.
___ other (write in) _____

Regarding "**education/learning**," my specific needs include: (Check all that apply.)
___ enrolling in community education programs.
___ enrolling in a certificate or degree program.
___ taking courses online.
___ finding classes tailored for elders/adults with disabilities.
___ becoming a better consumer of services.
___ becoming more computer literate.
___ preparing for my financial security in life.
___ eating healthier.
___ managing money/bills/claims.
___ coping with the challenges of aging.
___ preparing for another career or job.
___ maintaining a safe and injury-free home.
___ learning about fitness programs for health and wellness.
___ managing better my caregiving responsibilities.
___ other (write in) _____

Regarding "**family/caregiving/support networks**," my specific needs include: (Check all that apply.)
___ how to prepare for my or family member's long-term care.
___ finding reputable providers of home care services.
___ obtaining general information about caregiving and caregiver services.
___ finding caregivers to help me.
___ locating or securing a support group.
___ finding counseling services.
___ obtaining respite services (a break from caregiving).
___ finding a structured day program such as adult day care.
___ help with paying for my caregiving needs.
___ help with paying for my care recipient's caregiving needs.
___ help balancing my work and caregiving responsibilities.
___ learning how to manage my time and caregiving responsibilities.
___ other (write in)_____

Regarding "**financial security (money/finances)**," my specific needs include: (Check all that apply.)

___ securing government benefits that I may be eligible for such as Food Stamps or Supplemental Nutrition Assistance Program.
___ learning ways to be a "smart shopper" or better consumer.
___ help with housing expenses such as mortgage, utilities and home repairs.
___ help with health, medical or medication costs such as co payments.

___ help with transportation expenses such as gas and vehicle maintenance.
___ help with managing debt such as credit card bills.
___ help with preparing my taxes.
___ learning about local tax/fee relief programs for elders.

___ ways to improve my financial situation.
___ understanding my insurance policies such as health and home owner's insurance.
___ ways to save and invest my money.
___ how to protect my money, assets or property.
___ other (write in)_____

Regarding "**food and nutrition**," my specific needs include: (Check all that apply.)

___ affording groceries.
___ identifying places to buy nutritious and affordable food.
___ finding local food banks or pantries.
___ learning how to prepare healthy meals and snacks.
___ learning how to shop for healthy foods.

___ learning about safe handling of food.
___ finding congregate (group) meals site locations.
___ finding transportation to meal sites.
___ finding information about home delivered meals.
___ finding individualized nutrition counseling.

___ finding general information on good nutrition.
___ finding information on weight management.
___ finding information on nutrition to prevent or treat a disease.
___ learning about shelf stable food and how much water to stockpile for emergencies.
___ learning where to store and how to maintain emergency food and water.
___ other (write in) _____

Regarding "**health care**," my specific needs include: (Check all that apply.)

___ affording health insurance.
___ understanding my health insurance plan and health care system.
___ finding screening and immunization programs.
___ paying for out-of-pocket health care costs.
___ finding culturally and/or linguistically sensitive health care workers.

___ affording and/or managing my medications.
___ having someone help me appeal or resolve medical charges.
___ dealing with alcohol, drug and tobacco related illness.
___ dealing with cognitive impairment illnesses such as Alzheimer's Disease.
___ dealing with chronic physical conditions (e.g., diabetes and high blood pressure).

___ learning about health & wellness programs including injury prevention.
___ help with getting and paying for dental care.
___ help with getting glasses and paying for vision care.
___ help with getting and paying for a hearing aid.
___ accessing non-traditional medical services.
___ other (write in) _____

Regarding "**housing and home ownership**," my specific needs include: (Check all that apply.)

___ finding affordable housing.
___ finding affordable housing that is handicapped accessible.
___ learning about housing options in my community such as senior housing.
___ securing energy assistance such as fuel/ heating assistance.
___ adapting my home to meet my changing needs such as installing grab bars.

___ help with home maintenance and chores.
___ help with home repairs.
___ help with property taxes and/or fees.
___ help with utilities bills.
___ help making my home/apartment more secure or injury free.

___ getting legal assistance with housing issues.
___ locating "reputable" contractors.
___ facing foreclosure and getting help to keep my home.
___ other (write in) _____

Regarding "**legal assistance**," my specific needs include: (Check all that apply.)

___ finding affordable legal services.
___ learning about consumer rights, scams and frauds.
___ help with abuse, neglect or exploitation matters by another.
___ getting guidance on elder self-neglect.

___ learning about guardianship.
___ help with foreclosure or home ownership matters.
___ help with tenant issues.
___ help securing credit.
___ help dealing with creditors.

___ help filing income tax(es).
___ help preparing a will.
___ help with immigration, naturalization or citizenship matters.
___ appealing the "denied" decision for benefits or coverage.
___ other (write in) _____

Regarding "**leisure, recreation and fitness**," my specific needs include: (Check all that apply.)

___ learning about available leisure and recreational opportunities in my community.
___ finding recreational opportunities for elders or disabled adults.
___ finding recreational opportunities for men.
___ finding recreational opportunities for veterans.
___ finding recreational opportunities for culturally specific groups,

___ finding recreational opportunities for lesbian, gay, bisexual and transsexual (LGBT) persons.
___ finding recreational opportunities for my adult disabled child(ren).
___ securing transportation to participate in recreational opportunities.
___ participating in social activities (e.g., meals with friends, joining clubs).
___ participating in cognitive/mental activities (e.g., bridge, chess, book clubs, brain games).

___ participating in physical activities (e.g., dancing, swimming, walking clubs).
___ participating in injury prevention activities (e.g., falls, cuts, poisons).
___ finding and engaging in activities that promote balance.
___ finding and engaging in activities that promotes strength building.
___ finding and engaging in activities that promotes flexibility.
___ other (write in) _____

Regarding "**long-term care**," my specific needs include: (Check all that apply.)

___ learning about long-term care option for myself or another.
___ learning about ways to pay for long-term care needs.
___ securing health-related services.
___ securing medication management services.
___ securing personal care services.

___ securing homemaker/chore services.
___ securing social services.
___ securing protective services.
___ securing companionship services.
___ securing adult day care.

___ securing case management services.
___ securing home delivered meals.
___ securing transportation services.
___ participating in personal activities offered at senior centers.
___ other (write in) _____

Regarding "**maintain independence/dignity**," my specific needs include: (Check all that apply.)

___ getting my financial house in order so I can remain lifelong in my home.
___ securing resources to supplement my income to meet basic needs.
___ adapting my home to my changing health or physical needs.
___ learning about life style changes to maintain mental/physica l well being.
___ help to resolve a discriminatory practice such as age or sexual orientation matters.

___ planning for end-of-life care such as selecting a hospice program.
___ learning about long-term care options including long-term insurance.
___ having accessible and convenient public transportation options.
___ having walkable access to shops, parks and leisure activities along with well maintained streets and sidewalks.
___ learning about warning signs of unsafe driving/adjusting to life without driving.

___ maintaining social connection with others.
___ finding part time or full time employment.
___ having affordable housing options in a safe and secure community.
___ learning about volunteer/ civic opportunities in my community.
___ other (write in) _____

Regarding "**mental health**," my specific needs include: (Check all that apply.)

___ accessing mental health services.
___ finding mental health specialists who speak the same language as me such as the American Sign Language.
___ finding mental health specialists who understand my ethnic practices and culture.
___ finding approaches to mental health care that do not involve medications.

___ paying for mental health services.
___ help with balancing caregiving responsibilities and taking care of me.
___ securing services to address abuse, neglect or exploitation matters.
___ securing services to address depression or suicide.
___ securing services to address loss, grief or bereavement.

___ securing services to address drug/medication misuse or dependency.
___ learning life or coping skills such as working through conflict, stress or anger.
___ where to go if I need emergency services.
___ having to combat the ridicule or stigma attached to mental health conditions.
___ other (write in) _____

Regarding "**safety and security**," my specific needs include: (Check all that apply.)

___ recognizing and reporting physical and emotional abuse, neglect and exploitation.
___ recognizing and reporting financial exploitation or fraud.
___ recognizing and reporting self-neglect.
___ learning about evacuation procedures when a natural/man-made disaster occurs.

___ learning about which shelf stable food and how much water to stockpile for emergencies.
___ having litter/trash removed from streets, sidewalks and public spaces in my neighborhood.
___ having adequate street lighting for pedestrian safety and security.
___ having well-maintained, unobstructed sidewalks with visible curb cuts.

___ help in determining when I should cut back or stop driving.
___ learning about injury and accident prevention practices.
___ how I can make my neighborhood safer from crime for myself and elders.
___ how to get and use assistive technology to get around safety in my home and outside.
___ other (write in) _____

Regarding "**spirituality**," my specific needs include: (Check all that apply.)
___ learning more about my spiritual/ religious tradition's views on aging, death, and dying.
___ learning more about spiritual/religious approaches to coping with loss and grief.
___ learning more about other spiritual/religious traditions.
___ identifying religious/spiritual organizations in my community (e.g., churches, synagogues, mosques, temples, etc.).
___ securing transportation to religious/spiritual services and events.
___ in-home religious/spiritual services.
___ better integration of spiritual/religious concerns with end -of-life care.
___ more opportunities to discuss spiritual/religious issues wit h other elders and my family.
___ other (write in) _____

Regarding "**transportation/personal mobility**," my specific needs include: (Check all that apply.)
___ learning about transportation programs for elders/adults with disabilities.
___ getting handicapped accessible transportation services.
___ finding escort services for medical and other appointments.
___ help with defraying transportation costs.
___ having non-medical paratransit services, that is, passenger transportation with no fixed routes or schedules.
___ ability to have pickup appointments on short notice; not days in advance.
___ having rest areas at public transportation pickup sites.
___ having benches placed in the community to allow people with physical disabilities to rest.
___ having cross walk timers installed with ample time to cross the streets.
___ having injury-free side walks (including adequate street lights) and walking paths.
___ having larger print street signs.
___ help in deciding when to cut back or st op driving.
___ getting assistive devices to help me remain mobile in my home/outside.
___ other (write in) _____

Regarding "**volunteer/civic engagement**," my specific needs include: (Check all that apply.)
___ learning about available volunteer opportunities in my community.
___ finding volunteer opportunities specifically for elders and adults with disabilities.
___ finding how to become a mentor to children.
___ learning about my skills or abilities that I can bring to volunteer events.
___ securing transportation to volunteer events.
___ other (write in) _____

II. Service Areas of Focus

1. From among the listed items, which would you recommend **ELDER AFFAIRS** focus on between now and 2013? **(Select up to any FIVE items.)** If an area of your concern is not listed, please add under Other.

___ Provide additional information regarding elder abuse, fraud, exploitation and elder self neglect.
___ Expand affordable elder housing capacity and support options.
___ Educate residents about degenerative illnesses such as dementia/Alzheimer's Disease.
___ Encourage residents to plan for one's medical and non -medical long-term care.
___ Promote preventative health including screenings and immunizations.

___ Improve access to mental health services including screenings and support programs.
___ Promote fitness, exercise and recreational activities including injury/fall prevention programs.
___ Improve access/increase public and paratransit transportation options.
___ Promote personal preparedness planning such as financial security and chronic disease self-management.
___ Encourage employment retention, training/retraining and recruitment of older workers.

___ Promote social connections and volunteer/civic engagement in the community.
___ Increase home and health care workforce.
___ Re-examine the role of senior centers.
___ Establish a single, coordinated system of information and access for all persons seeking long term supports.
___ Other (write in) _____

2. From among the items listed, which would you recommend **YOUR COMMUNITY** focus on between now and 2013. (**Select up to any FIVE items**.) If an area of your concern is not listed, please add under Other.

___ Help prepare residents for its aging population.
___ Expand affordable elder housing capacity and support options.
___ Expand options to help elder homeowners with increasing cost of home ownership.
___ Assist elders with home modification, repair and maintenance services.
___ Promote preventative health care, screenings and immunizations.

___ Improve access to mental health services including screening and support programs.
___ Promote fitness, exercise and recreational activities including injury/fall prevention programs.
___ Improve access/increase public and paratransit transportation options.
___ Promote pedestrian and driver safety in community design and planning.
___ Encourage employment retention, training/retraining and recruitment of older workers.

___ Promote social connections and volunteer/civic engagement in the community.
___ Improve our emergency response capacity.
___ Re-examine the role of senior centers.
___ Better planning to reflect residents' vision of "livable" neighborhoods.
___ Other (write in) _____

III. Socio-Demographic Characteristics – OPTIONAL

To better summarize the findings for the U.S. Administration on Aging, we would appreciate your providing us with some socio-demographic information.

1. Five-digit zip code: __ __ __ __ __

2. Gender: ___ Male ___Female

3a. Race: Please pick one of the answers below.

___ White	___ Asian
___ Black/African-American	___ Native Hawaiian/Other Pacific Islander
___ American Indian/Alaska Native	___ Multi-racial/other

3b. Are you of Spanish, Hispanic, or Latino heritage? ___ Yes ___ No

4. Which best portrays your age group? Please pick one of the answers below.

___18-34	___45-49	___60-64	___75-79
___35-39	___50-54	___65-69	___80-84
___40-44	___55-59	___70-74	___85+

5. Which best portrays your employment status?

___ On average, I currently work 35 or more hours per week.
___ On average, I currently work between 20 and 35 hours per week.
___ On average, I currently work less than 20 hours per week.
___ Although looking, I am currently unemployed.
___ I am retired or no longer in the labor force.

6. Which best portrays your housing status?

___Home owner ___Renter ___Other _____

7. & 8. Based on the number of people in your household, which best portrays your total annual household income?

Household Number	Total Annual household income	Household Number	Total Annual household income
___1 perso	___ Under $10,400 ___ $10,400-$20,799 ___ $20,800-$31,199 ___ $31,200-$41,599 ___ $41,600 and over	___ 4 persons	___ Under $21,200 ___ $21,200-$42,399 ___ $42,400-$63,599 ___ $63,600-$84,799 ___ $84,800 and over
___2 persor	___ Under $14,000 ___ $14,000-$27,999 ___ $28,000-$41,999 ___ $42,000-$55,999 ___ $56,000 and over	___5+ persons	___ Under $24,800 ___ $24,800-$49,599 ___ $49,600-$74,399 ___ $74,400-$99,199 ___ $99,200 and over
___3 persor	___ Under $17,600 ___ $17,600-$35,199 ___ $35,200-$52,799 ___ $52,800-$70,399 ___ $70,400 and over	___ Skip item	

9.a An informal caregiver is defined as an adult (typically a family member or friend) who provides unpaid assistance to another adult who can no longer

independently attend to his or her personal needs and/or perform his or her normal activities of daily living.

Are you currently an informal caregiver to an elder or adult with disabilities, OR a grandparent or other relative caregiver age 55 years and older responsible for the care of a child age 18 or younger?

___ Yes, an informal caregiver for another.
___ Yes, an informal caregiver to more than one person.
___ No (If this response, skip 9.b.)

9.b I am the caregiver for my: Please check all that apply.

___Spouse	___Grandparent
___Significant other/domestic partn er	___Grandchild
___Father (stepfather)	___In-law relation
___Mother (stepmother)	___Friend/neighbor/other
___Sibling	___Skip question

Please provide any additional comments about your service needs.

Paper version of the
Survey of Elder Service Needs
posted at http://www.800ageinfo.com/

Responses are invited through
December 15, 2008.

Return completed survey to:

Executive Office of Elder Affairs
Research and Data Unit
One Ashburton Place, Fifth floor
Boston, MA 02108

Appendix B

Table AAA_3a

Issues Voiced by Participants From 206 AAAs Events

Domains				Tot	%
HEALTH CARE	N	ST	%	101	16.8
Affordable health care		**37**	**36.6**		
health care costs/high costs of medical expenses-- affordable health care	6				
can't afford co-payments/balances after insurance payments	4				
can't afford medication/prescription drugs/too expensive	11				
more affordable medication programs	11				
affordable or financial help w/ dental/sensory services	5				
Health insurance issues other than affordability	3	**17**	**16.8**		
insurance doesn't cover needed services (e.g. assistive technologies -- wheelchair)	1				
insurance coverage or better coverage for dental/vision/hearing and prescription drugs benefits	10				
better insurance plan (to cover physicals, screenings); affordable health plan	3				
Dental/vision/hearing (need, access) other than affordability		**12**	**11.9**		
(access to) affordable dental care	9				
question if dentist actually provides "elder rates"	1				
sensory - vision and hearing	2				
Prescription assistance other than affordability	4	**9**	**8.9**		
medication management	2				
negative side effects of medications; multiple medications	3				
Concern about health/health problems		**12**	**11.9**		
concern about health/health problems (e.g., memory loss, physical disability, chronic diseases)	10				
AD and related dementia	1				
injury/falls prevention -- concern about mobility	1				
Assistance w/ medical personnel & support w/ pre and post services		**10**	**9.9**		
MD so pressed for time w/ appointments, elders need help to prepare questions ahead of time	1				
access to seeing a doctor/getting a hold of doctors/ need more doctors	4				
quality of interaction w/ medical professionals	1				
advocate for doctor's visits	2				
coordinating health services	1				
assistance after procedures and help "getting settled" at home	1				
Health education	2	**3**	**3.0**		
men's tendency to self-diagnose and self-medicate	1				
Need medical supplies/assistive technology	1	**1**	**1.0**		
TRANSPORTATION	N	ST	%	**97**	16.1
Access to transportation services for….	27	66	68.0		
medical appointments/out of town appointments	29				
social activities/extra curricula activities	8				
basic errands (e.g., grocery store)	1				
congregate meal site	1				
Public transportation		20	20.6		
public transportation unreliable -- want pick ups and returns trips on time	4				
public transportation more frequent; bus runs once an hours (shorter bus trips)	8				
medical ride on short notice (e.g., appointment cancellation by another patient)	1				
personalized transportation; more flex hrs	1				
absence of transit services	5				
public transportation difficult for frail elders to use.	1				
Affordable transportation options (chair, door-to-door) -- includes access to	4	10	10.3		
more taxi vouchers	2				

affordable medical transportation	3				
more subsidized options/discount passes	1				
Escort/assistance of someone					
medical escort	1	1	1.0		
FINANCIAL SECURITY	N	St	%	**82**	13.6
Insufficient income (from SS or Welfare)	13	52	63.4		
For food	4				
For home/housing related					
bills	6				
taxes	2				
rent/mortgage	8				
utilities	2				
home repairs	3				
For Health care					
dental care	1				
prescription drugs	11				
paying for medical bills/treatment	2				
Increase Cost of living	7	14	17.1		
prices increasing -- worry about making ends meet	6				
prices are (too) high	1				
Staying connected w/ family	9	10	12.2		
visit children; child's medical appointments	1				
Other		6	7.3		
mental health services	2				
tax preparation	2				
concerns about sources of income -- SS privatization	1				
leisure activities	1				
HOUSING/HOME OWNERSHIP	N	ST	%	**75**	12.5
Affordable housing (Housing supports)	7	28	37.3		
rent control	4				
more (low income/subsidized) housing for seniors	11				
alternative senior housing	4				
lack of housing support for people with mental health needs	1				
need for LGBT friendly housing.	1				
Help w/ home repairs/maintenance/…	3	24	32.0		
home modifications	1				
prepare residence so elder can remain in setting	1				
home repairs	18				
home maintenance	1				
Increasing home/housing expenses					
increasing energy (gas/oil) prices		18	24.0		
cost of maintaining home (especially w/ rising energy costs)					
increasing local taxes and fees (i.e., property, excise, water, sewer, other fees)	5				
rent/utilities is too high	1				
high utilities bills	3				
fuel assistance	9				
Other		5	6.7		
tenant issues (BHA, management company, etc.)	2				
better maintenance in the projects (done by management company)	1				
more social activities -- including in Spanish language	1				
parking & clearing snow off their cars	1				
MAINTAIN INDEPENDENCE/DIGNITY	N	ST	%	**52**	8.6
Isolation	7	20	38.5		
seniors being alone no family/friends	1				
social/support -- social connections	7				

relationship/connections	3				
inability to be mobile -- get around	1				
wellness check	1				
Information and assistance	6	11	21.1		
absence of essential infrastructures in the community	1				
entire elder service programs and services made available to LGBT	1				
find "reliable" (fee-for-service) providers/contractors	1				
assistance applying for programs/services (e.g., SSI, SNAP, fuel assistance)	2				
Language barrier	3	7	13.5		
difficulty getting services for the Haitian Community	1				
language barriers with others in the community	2				
translation/interpreter services	1				
Life transitions		9	17.3		
loss of roles and change of role	6				
prepare/plan for desired/future lifestyle	1				
concern/ability to remain independent as one become immobile	2				
Cultural/Sexual orientation	2	4	7.7		
sexual orientation	1				
cultural barriers (e.g., older Hispanics)	1				
Self-determination -- Control/maintain direction of (medical) care	1		1.9		
FAMILY/CAREGIVING/SUPPORT NETWORKS	N	ST	%	**46**	7.6
Caregiver Support Program	5	19	41.3		
information and referral	2				
counseling	1				
support groups	6				
respite services	3				
companionship	1				
grandparents	1				
Informal caregiver barriers		12	26.1		
limited support by family members	1				
desire more family involvement but unsure how to ask for that/make it happen	2				
direct service help for caregiver	6				
financial support	2				
additional funds to home care programs	1				
Reasons given to support caregivers		10	21.7		
provides medical escort for care recipient	1				
serves as Interpreter for care recipient	1				
manages/coordinates services for care recipient	1				
emotional/general support/encouragement of caregivers	3				
undertake the role of advocate and support person	4				
Training topics/education for caregiver	2	5	10.9		
education/support for caregivers/elders with AD diagnosis or dementia	1				
stress reducing techniques	1				
intergenerational programs	1				
FOOD AND NUTRITION	N	ST	%	**33**	5.48
Hunger/Food Insecurity		17	51.5		
affording groceries/food prices too high	12				
need more food programs to supplement food	5				
Meal preparation		1	3.0		
learning how to prepare healthy meals and snacks	1				
Meal Services for Elders		5	15.2		
more meal variations	2				
congregate meal open on weekends	2				
quality of meals	1				

Nutrition Education	1	1	3.0		
Food Stamp Program	2	7	21.2		
monthly FS allotment is insufficient -- more FS/more money	5				
Other		2	6.1		
need a general store	1				
grocery shopping assistance available on weekends	1				
LONG-TERM CARE	N	ST	%	**30**	5.0
Need for Home Care including ADH/DC	7	14	46.7		
Homemakers	1				
Chore services (housecleaning, laundry	4				
Companions	1				
Adult Day Heath/Day Care	1				
Information for LTC (e.g., where to call)	1	7	23.3		
finding (reliable) in-home service providers/individuals	5				
understanding existing community service	1				
Service Delivery		7	23.3		
assessment and care coordination	1				
quality of homemaking service -- inadequate	1				
develop working force	1				
need for more health care workers to assist elders in home	1				
more inclusion of other parties in continuum of care plan (e.g., faith based, friends, neighbors, etc.)	1				
elders remaining in nursing home too long when can live in community setting	2				
Preparation for managing own or family member's long -term care	2	2	6.7		
SAFETY AND SECURITY	N	ST	%	**26**	4.3
Crime/Violence/Drugs	2	11	42.3		
crime/violence in neighborhood/ drugs and increased in the neighborhood	2				
more police visibility/enforcement of pedestrian friendly laws	5				
seniors target of crime/senior safety/crimes against seniors	1				
crime in public housing developments	1				
Safe home living situation	1	8	30.8		
RU OK telephone System	1				
quicker communication w/ police/fire	1				
home is safe from accidental injuries especially falls	1				
home repair/modification	3				
Do Not Call list -- should not be getting calls from politicians and charities	1				
Public services -- Livable neighborhood	1	5	19.2		
handicapped accessible issues -- MBTA, sidewalks,	1				
sidewalks needs repair; curbs cuts; accessibility	1				
more crosswalks	1				
roadside trees cut and split	1				
Types of abuse		2	7.7		
abuse or neglect	1				
financial exploitation	1				
MENTAL HEALTH	N	ST	%	**21**	3.5
Access to MH services	8	14	66.7		
transportation to MH Counseling sessions	1				
providing MH services in the home	4				
need MH services	1				
MH Counseling services	1	3	14.3		
MH services to address depression and/or anxiety	2				
Emotional barriers (e.g., not using services due to mental illness)	2	2	9.5		
Other		2	9.5		
affording MH Services (no ins or can't afford copay)	1				
quality of MH services (physicians often do not screen elders for MH problems)	1				

LEISURE, RECREATION & FITNESS	N	ST	%	**19**	3.2
Activities/Recreation	5	10	52.6		
more activities	3				
social activities	1				
place to gather	1				
Exercise/fitness	8	8	42.1		
Accessible recreation	1	1	5.3		
EDUCATION	N	ST	%	12	2.0
Classes		8	66.7		
computer classes	3				
English classes/ESL	4				
skill development	1				
Information related to aging	2	3	25.0		
Alzheimer's Disease	1				
Other: Residents may want computer	1	1	8.3		
LEGAL ASSISTANCE	N	ST	%	5	0.8
Eviction/housing	1	1			
Immigration	3	3			
Guardianship	1	1			
VOLUNTEER/CIVIC ENGAGEMENT	N	ST	%	**3**	0.5
Expanding awareness of community center in the region	1	3			
Volunteer pertain to low vision elders	1				
Voting/ election	1				
CAREER/EMPLOYMENT	N	ST	%	0	0
SPIRITUALITY	N	ST	%	0	0
	602	602		602	100

Appendix C

Table PQ_1

Service Regions of Providers

Service Region	Frequency	Percent
Provider Serving Single Service Region (n=68; 78.2%)		
Southeast Massachusetts (SM)	3	3.4
Western Massachusetts (WM)	10	11.5
South Shore (SS)	16	18.4
North Shore (NS)	14	16.1
Metrowest (MW)	3	3.4
Greater Boston (GB)	13	14.9
Central Massachusetts (CM)	6	6.9
Cape and the Island (CI)	3	3.4
Provider Serving Multiple Service Regions (n=19; 21.8%)		
GB & SS	1	1.1
GB & MW	1	1.1
CM & MW	1	1.1
CM & GB	2	2.3
CI & SS	1	1.1
GB, NS & SS	1	1.1
GB, MW & SS	2	2.3
GB, MW & NS	1	1.1
CM, SS & WM	1	1.1
CI, GB & SS	2	2.3
CI, GB, MW & SS	1	1.1
GB, MW, NS & SS	1	1.1
CI, CM, BG & MW	1	1.1
CM, GB, MW, SS & WM	1	1.1
CI, GB, MW, NS, & SS	1	1.1
CI, CM, GB, MW, NS & SS	1	1.1
Providers Serving Each Region	N	
Cape and the Islands	10	
Central Massachusetts	13	
Greater Boston	29	
Metrowest	14	
North Shore	19	
South Shore	29	
Western Massachusetts	12	
Southeast Massachusetts*	3	

*An under count since this region was inadvertently omitted and respondents wrote in response.

Chart PQ_1

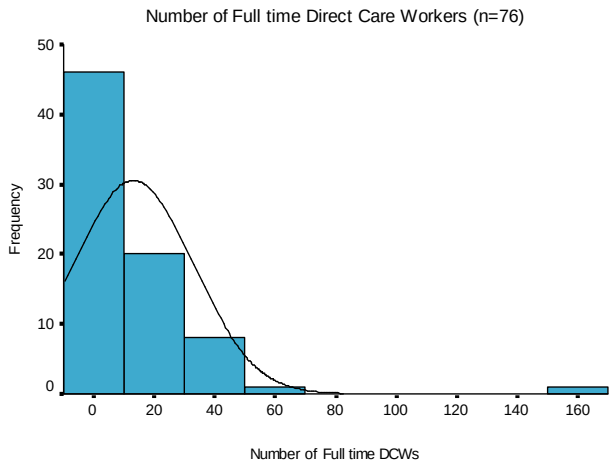
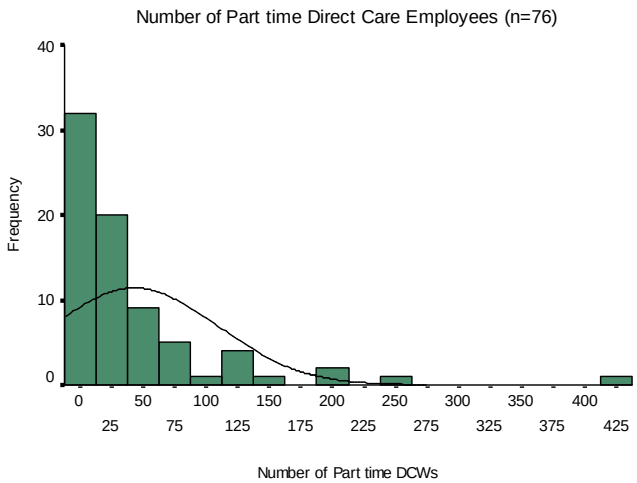


Chart PQ_2



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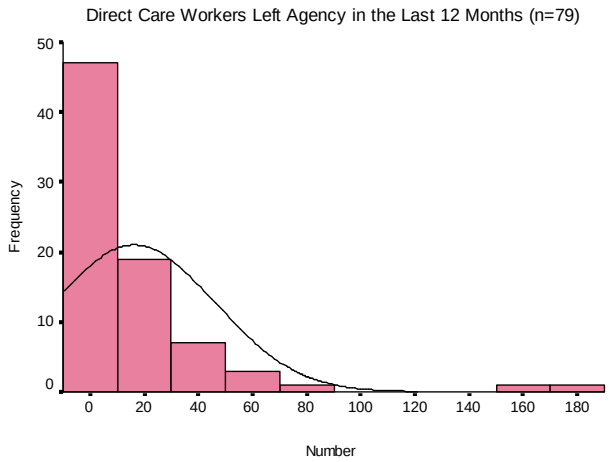

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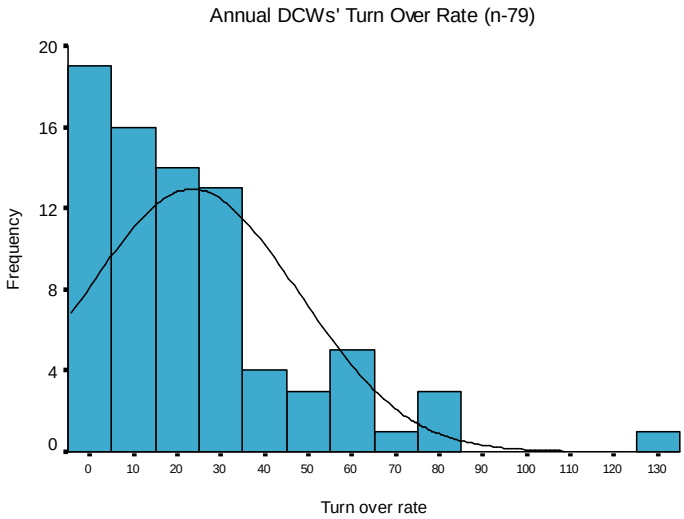


Table PQ_9
Practices In Employing Direct Care Workers

My agency will focus on…	Total N	Current Practice			Very Likely		Likely		No Change		Unlikely		Very Unlikely	
			N	%	N	%	N	%	N	%	N	%	N	%
A. Increasing or Providing Competitive Wage Compensation	70	Yes	68	97.1	46	67.6	15	22.1	7	10.3				
		No	2	2.9							2			
B. Providing job security.	69	Yes	61	88.4	40	65.6	12	19.7	9	14.8				
		No	8	11.6	2		2		4					
C. Reducing the numbers of on-the-job injuries or safety.	72	Yes	70	97.2	52	74.3	11	15.7	7	10				
		No	2	2.8					1				1	
D. Offering health insurance that DCWs can pick up and afford.	70	Yes	57	81.4	32	45.7	13	18.6	11	15.7	1	1.4		
		No	13	18.6	1	7.7	1	7.7	5	38.5	1	7.7	5	38.5
E. Recruiting qualified/skilled DCWs.	70	Yes	69	98.6	51	73.9	11	15.9	7	10.1				
		No	1	1.4					1					
F. Serving non-English speaking and culturally diverse populations.	73	Yes	58	79.5	37	63.8	13	22.4	8	13.8				
		No	15	20.5			5	33.3	6	40.0	4	26.7		
G. Serving elders in rural or remote areas.	73	Yes	45	61.6	23	51.1	13	28.9	9	20.0				
		No	28	38.4			2	7.1	11	39.3	10	35.7	5	17.9
H. Providing compensation for travel time/transportation expenses	70	Yes	47	67.1	29	61.7	8	17.0	10	21.3				
		No	23	32.9			6	26.1	6	26.1	7	30.4	4	17.4
I. Reducing the DCWs' turn-over rate.	69	Yes	66	95.7	45	68.2	17	25.8	4	6.06				
		No	3	4.3			1		2					
J. Ensuring English language competency for DCWs whose first language is not English.	70	Yes	41	58.6	22	53.7	12	29.3	5	12.2	1	2.4	1	2.4
		No	29	41.4	4	13.8	6	20.7	14	48.3	4	13.8	1	3.5
K. Developing a career advancement program for DCWs.	70	Yes	37	52.9	20	54.1	12	32.4	4	10.8	1	2.7		
		No	33	47.1	4	12.1	10	30.3	15	45.5	4	12.1		
L. Improving the job image of DCWs.	70	Yes	62	88.6	40	64.5	14	22.6	7	11.3			1	1.6
		No	8	11.4	1		1		6					
M. Including DCWs when reassessing clients' care plans.	70	Yes	56	80.0	34	60.7	10	17.9	12	21.4				
		No	14	20.0	3	21.4	4	28.6	3	21.4	2	14.3	2	14.3
N. Improving supervision/management practices for DCWs.	71	Yes	65	91.5	44	67.7	13	20.0	8	12.3				
		No	6	8.5			4		2					
O. Ascertaining clients' satisfaction with our direct care services.	71	Yes	71	100.0	56	78.9	10	14.1	5	7.0				
		No	0											

Table PQ_10
Major Challenges Currently Facing DCWs and Suggestions to Help Resolve Cited Challenges

Challenge	Solution
POLICIES	
Level playing field across agencies – agencies not carry fair share of tax burden for their workers	Enforcement around agencies that circumvent the law
• Client "not home" • No cost reimbursement when client is not at home • Not told that ASAP does not reimburse provider • Inability to bill for client not home – DCW loses out travel time, gas and no wages	
Staffing long-term care when shifts are 24/7 8-hour shifts not realistic for elders w/ dementia or infirmed	It is not realistic that the elderly and/or infirm be forced to have shift changes in their home very 8 hours. It is confusing and overwhelming for them. If dementia is involved, providing a successful rehabilitative plan is nearly impossible with frequent shift changes. For those without dementia it is unnerving and stressful. At minimum a 10-hour shift, or even better, 12-hour shift should be allowed without adding to the elders' financial burden to pay overtime.
• Eligibility for Unemployment Compensation • No motivation to work more than 30 hours for benefits (most receive MassHealth).	Suggest Mass Health/the State of MA closely monitor their recipients -- TOTAL misuse of our $'s that goes to young women who know how to "use the system"!!
• High percentage work 2-3 months then quit so that they can collect unemployment.	
OPERATIONAL	
Remaining competitive -- wages	
• No administrative adjustment when mandatory pay increase are implemented • reimbursement inadequate to cover salaries and wages at a competitive rate • insufficient $ to compensate DCWs adequately • reimbursement rates restricted by state • Providing competitive wages (wages are falling vs. inflation) • Livable wages for DCW	Increase reimbursement rate; currently too low Increase amounts we can bill the ASAP's so we can increase wages Higher reimbursement rates Increase state supported program to allow competitive pay rates Increase funding – able to offer higher wages Competitive wages and benefit package Have reimbursement rate keep up with increasing costs.
Reduce turn over rate or retention of (quality) DCWs	Offer career-ladder opportunities More $ devoted to advertising to solve TOR
Preventing burn out	
Staff aging in place	
Lack of work ethics/professionalism	
• Little or lack of work ethics • Lack sense of responsibility/accountability to patients/employers Absence of professionalism	Include ethics in training program Stricter candidate selection
Challenge	**Solution**
Recruitment	
• Increase in competition for DCWs who excels • Limited number of available DCWs	Increase funding – able to find quality workers More $ devoted to advertising to solve TOR

• Finding qualified DCWs • Finding dependable people • Finding staff who can be caring and respectful towards clients	Referrals from DCW presently aboard Attract new people by marketing job satisfaction that comes with the job Continual advertisement Increasing the pay rate of DCWs will bring many interested into the job. Offering Health Insurance will have a plus. Job Security.
Language barriers	Competence standards prior to hire
• Reading and writing skills	
Stabilization of DCWs working hours	
• Difficulty providing FT hours when clients live far apart • Inability to provide 40 hours – travel time; number of hours • Insufficient working hours to cover travel time for multiple clients living distance from each other	
Non statutory compensation and benefits insurance	
DCWs' WORKING CONDITIONS	
Recruitment -- lack of interest due to low wages	
Mileage/travel costs	Gas stipends
• Gas prices – affects length of shifts that agency provides • Travel reimbursement when reimbursement rates low • Travel expenses for cases/client in out of reach areas • Cost of gasoline (Cost forcing them to leave the industry)	
No health insurance offered	
Health insurance not affordable to DCW	
OTHER	
Lack of respect towards workers	
Human services field under appreciated	

Appendix D

Table MQ_1

224 Municipalities

Acton	Clinton	Huntington	Newburyport	Sturbridge
Acushnet	Dalton	Ipswich	Norfolk	Sudbury
Adams	Danvers	Lanesborough	North Adams	Sutton
Agawam	Dartmouth	Lawrence	North Andover	Swampscott
Alford	Dedham	Lee	North Attleboro	Tewksbury
Amherst	Dennis	Leominster	North Brookfield	Tolland
Andover	Douglas	Leverett	North Reading	Tyngsborough
Aquinnah	Dover	Lexington	Northfield	Tyringham
Arlington	Dudley	Lincoln	Norwell	Upton
Ashland	Dunstable	Littletown	Oak Bluffs	Walpole
Attleboro	Duxbury	Longmeadow	Oakham	Waltham
Auburn	Easthampton	Lowell	Orange	Ware
Ayer	Easton	Ludlow	Oxford	Watertown
Barnstable	Edgartown	Lunenburg	Palmer	Wayland
Barre	Egremont	Lynn	Paxton	Webster
Becket	Everett	Lynnfield	Pelham	Wellfleet
Bedford	Fairhaven	Malden	Pembroke	Wendell
Bellingham	Fall River	Manchester-by-the-Sea	Pepperell	West Boylston
Berkley	Fitchburg	Mansfield	Pittsfield	West Brookfield
Berlin	Florida	Marblehead	Plainville	West Newbury
Bernardston	Foxborough	Marion	Plymouth	West Springfield
Billerica	Framingham	Marlborough	Plympton	West Stockbridge
Blackstone	Georgetown	Marshfield	Randolph	West Tisbury**
Blandford*****	Gill*	Mashpee	Reading	Westborough
Bolton	Grafton	Mattapoisett	Rehoboth	Westfield
Boston	Granville	Maynard	Rockland	Westhampton
Bourne	Great Barrington	Medford	Rockport	Westminster
Boxborough	Greenfield	Medway	Rowley	Weston
Boxford	Groveland	Melrose	Russell	Weymouth
Boylston	Halifax	Merrimac	Salem	Whitman
Braintree	Hanover	Methuen	Salisbury	Wilbraham
Brewster	Hanson	Middeborough	Sandwich	Williamsburg
Brimfield	Harvard	Middlefield	Savoy	Winchester
Brockton	Harwich	Middleton	Scituate	Windsor
Brookfield	Hatfield	Milford	Sherborn	Winthrop
Brookline	Haverhill	Millbury	Shirley	Woburn
Burlington	Hawley	Millis	Shrewsbury	Worcester
Canton	Heath	Milton	Shutesbury	Worthington
Carver	Hingham	Monson	Somerset	Wrentham
Charlemont	Holden	Montague	Somerville	Yarmouth
Chatham	Holliston	Montgomery	South Hadley	
Cheshire	Holyoke	Needham	Southborough	
Chester	Hopedale	New Bedford	Southwick	
Chesterfield	Hopkinton	New Braintree	Spencer	
Chicopee	Hudson	New Marlborough	Sterling	
Chilmark	Hull	Newbury	Stoneham	

Table MQ_6a
Brief Descriptions of Initiatives to Address Anticipated Increase EMS Service Calls

Municipality	Initiative
Acton	Purchase of second ambulance.
Attleboro	1. BNEPG: see description attached; 2. Emergency Preparedness plan for seniors
Boxborough	Medical Reserve Corp. L.E.P.C.
Boxford	CPR training being offered in January 09 to entire community. Balance and other exercise classes.
Dudley	We are trying to provide full time EMT service instead of the present on call program.
Georgetown	Increased and improved communication between EMS/Fire/Police, COA and ESMV).
Great Barrington	We are currently working on Triad in the Town of Gt. Barr. And one of our goals is to target the homebound seniors.
Hanson	Disaster Plan
Holyoke	Development of a team comprised of police, fire, COA and BOH to follow up on elders identified through EMS calls
Hopedale	Emergency management Planning -- Special Needs Database/Registry Hopedale has an Emergency Management Database. Residents may self -identify as individuals who could not self-shelter or self-evacuate in the event of a town-wide emergency. The COA is the lead agency. This is a joint project with EMS and the Board of Health. We are in year 2 of the project. The COA Outreach Worker monitors many of these individuals in an effort to address issues before problems become unmanageable.
Mansfield	Ambi pro program -- Fire department
Marshfield	Yes, open house, Triad Group, and working with COA. Thinking about a MCAT Marshfield Community Action Team to possibly up mobil ity
Needham	The Fire Department is planning to include the seniors in the Students Awareness of Fire Safety (SFE) Program. The Fire department will offer a presentation on fire and general safety for seniors, with a focus on preventing falls which is a le ading cause of injuries for older residents.
New Marlborough	Obtaining new ambulance
Pembroke	Pembroke Emergency Management Team -- coordinated effort with police and fire depts' -- especially with and after e-coli and coliform water situation.
Randolph	Chief Charles Foley, Randolph Fire Department provides Safety and Public Information that is Elderly Specific.
Sandwich	The Town is studying [the] opening a fire station in E. Sandwich to better serve that area of Sandwich.
Shrewsbury	Through our TRIAD, our Outreach Coordinator works with Police, Fire and EMS to review calls that are made and how we can be more proactive. For 2009, we know we will need to focus on fall prevention, due to the number of calls that were received due to falls.
Swampscott	Triad --- lock boxes -- Yellow medical cards (Are you ok? Calls)
Tyringham	Purchase by town of emergency medical vehicle, "Rescue One".
Wayland	Interfacing with local Emergency Planning Committee. Workshops, dealing with emergency preparedness.
West Boylston	Grant received to add 2 additional firefighters/EMT's full time on the department.

Table MQ_10a
Multi Departments Responsible for Maintaining/Updating Registry

Three - Five Departments	Frequency N=16	Percent	Cumulative Percent
Emergency Management**, Board of Health & Council on Aging	1	6.25	6.3
Emergency Management**, Board of Health, Senior Center & Commission on Disability	1	6.25	12.5
Emergency Management**, Fire Department & Council on Aging	1	6.25	18.8
Emergency Management**, Fire Department & Police Department	1	6.25	25.0
Emergency Medical System, Fire Department & Police Department	2	12.5	37.5
Fire Department, Board of Health, & Council on Aging	1	6.25	43.8
Fire Department, Board of Health, & Senior Center	1	6.25	50.0
Fire Department, Board of Health, Council on Aging & Conservation Agency	1	6.25	56.3
Fire Department, Police Department & Council on Aging	2	12.5	68.8
Fire Department, Police Department, Board of Health & Council on Aging	1	6.25	75.0
Fire Department, Police Department, Board of Health, Council on Aging, and Volunteers with EMS Skills	1	6.25	81.3
Fire Department, Police Department, Council on Aging & County Sheriff's Department	1	6.25	87.5
Police Department, Board of Health & Social Services Department	1	6.25	93.8
Police Department, Senior Center & Advocacy group volunteers	1	6.25	100.0

** Emergency Management includes Civil Defense and Emergency Response or Preparedness Team .

Table MQ_15a
Part C. Community Preparedness

We see to ascertain the "aging readiness" of communities. The following areas are generated from livable communities and aging in place literature.

An inventory of activities or practices is listed under each area. Please indicate the status of each activity or practice in your community based on the following:
Exists = The activity/practice exists in my community.
Dialogue = Although the activity/practice does not exist in my community, a dialogue is occurring.
None = The activity/practice does not occur in my community.
N/A = The activity/practice does not apply to my community.

Item #	1. Community Governance: My community has...	N = 197				Percent			
		E	D	N	N/A	E	D	N	N/A
5)	Established connections and communication between the COA and other municipal departments.	173	14	7	3	87.8	7.1	3.6	1.5
2)	A COA director recognized as a municipal department head.	171	6	15	5	86.8	3.0	7.6	2.5
4)	Established connections and communication between other the COA and community resources.	169	17	9	2	85.8	8.6	4.6	1.0
6)	Information about the COA on the website.	163	13	10	11	82.7	6.6	5.1	5.6
3)	Coordination of projects between local government and local AAA as well as other social services agencies or organization.	131	28	29	9	66.5	14.2	14.7	4.6
9)	Regular opportunities for public input into municipal plans and actions affecting elders.	120	45	22	10	60.9	22.8	11.2	5.1
7)	Official municipal policies specifying the importance of including elders and their concerns in all program development and decision-making processes.	61	62	64	10	31.0	31.5	32.5	5.1
1)	A community action plan which includes the needs of older adults and recommendation to help meet these needs.	59	75	50	13	29.9	38.1	25.4	6.6
8)	Plans to ensure all land use patterns, transportation routes, and community facilities meet the needs of an aging society.	40	85	57	15	20.3	43.1	28.9	7.6
	Overall response	1087	345	263					
		64.1	20.4	15.5					

Item #	2. Building/Zoning Codes: My community has...	N = 183				Percent			
		E	D	N	N/A	E	D	N	N/A
1)	Building codes that require "universal design" (e.g., construction of wheelchair ramps, doorway size of at least 32" wide with swing clear hinges, location of electrical outlets 18"-48" above the floor, hallway widths at least 42", etc.).	140	17	24	2	76.5	9.3	13.1	1.1
4)	Zoning codes that allow multifamily housing.	136	14	22	11	74.3	7.7	12.0	6.0
2)	Zoning codes that allow accessory dwelling units.	125	20	18	20	68.3	10.9	9.8	10.9
3)	Zoning codes that allow mixed use and pedestrian- friendly development in appropriate areas (such as town center).	122	27	19	15	66.7	14.8	10.4	8.2
5)	Zoning codes that support the development of assisted living facilities.	99	30	39	15	54.1	16.4	21.3	8.2
	Overall response	622	108	122					
		73.0	12.7	14.3					

Item #	3. Pedestrian and Driver Safety: My community has...	N = 193				Percent			
		E	D	N	N/A	E	D	N	N/A
7)	Well-maintained, unobstructed sidewalks with visible curb cuts.	121	28	29	15	62.7	14.5	15.0	7.8
6)	Street crossings made safe and accessible (e.g., bump-outs, crosswalk countdown, island in middle of the street, etc.).	108	23	44	18	56.0	11.9	22.8	9.3
2)	Adequate lighting along sidewalks for pedestrians to be and feel safe.	105	24	41	23	54.4	12.4	21.2	11.9
5)	Mid-block crosswalks or pedestrian traffic signals on long streets with no intersections.	97	14	52	30	50.3	7.3	26.9	15.5
4)	Locations where indoor walking can take place (e.g., shopping malls) which are open for community walkers.	72	6	89	26	37.3	3.1	46.1	13.5
3)	Benches at regular intervals along "pedestrian routes" to allow people with physical limitations to rest.	63	28	76	26	32.6	14.5	39.4	13.5
8)	Road design tailored to the needs of older adult drivers (e.g., larger signage, left turn lanes, road markings, etc.).	59	31	81	22	30.6	16.1	42.0	11.4
1)	A walkability plan.	53	53	63	24	27.5	27.5	32.6	12.4
	Overall response	678	207	475					
		49.9	15.2	34.9					

Item #	4. Social Services: My community has...	N = 198				Percent			
		E	D	N	N/A	E	D	N	N/A
3)	A central phone number that people can call when they need assistance but do not know where to turn.	167	13	16	2	84.3	6.6	8.1	1.0
1)	A single entry point or one-stop-shop for elder resources and services.	160	9	21	8	80.8	4.5	10.6	4.0
2)	A directory of services available to elders in need.	156	27	11	4	78.8	13.6	5.6	2.0
4)	A follow-up process to make sure people got connected with the appropriate group or organization.	131	32	29	6	66.2	16.2	14.6	3.0
5)	A service that provides people to run errands for elders.	91	39	65	3	46.0	19.7	32.8	1.5
	Overall response	705	120	142					
		72.9	12.4	14.7					

Item #	5. Career/Workforce Development: My community has...	N = 184				Percent			
		E	D	N	N/A	E	D	N	N/A
5)	The Senior Community Service Employment Program.	52	6	119	7	28.3	3.3	64.7	3.8
1)	An employment placement service with staff skilled in placing seniors.	39	9	134	2	21.2	4.9	72.8	1.1
3)	Job retraining opportunities.	37	9	134	4	20.1	4.9	72.8	2.2
4)	The Career Center/One Stop.	37	6	136	3	20.1	3.3	73.9	2.7
2)	Job banks for older adults.	23	14	142	5	12.5	7.6	77.2	2.7
	Overall response	188	44	665					
		21.0	4.9	74.1					

Item #	6. Education/Learning: My community has...	N = 197				Percent			
		E	D	N	N/A	E	D	N	N/A
3)	Community sponsored events that promote culture such as concerts, shows, celebrations, etc.	179	4	13	1	90.9	2.0	6.6	0.5
6)	Information programs on topics of interest to elders offered at community centers or other public facilities.	177	6	10	4	89.8	3.0	5.1	2.0
4)	Community sponsored events that promote fine arts and crafts such as water color, knitting, quilting, needlepoint, etc.	172	7	15	3	87.3	3.6	7.6	1.5
7)	Library information programs such as book discussions and speakers on topics of interest to elders.	164	14	16	3	83.2	7.1	8.1	1.5
8)	Low-cost programs to teach elders how to use the computer (e.g., navigation and research skills).	147	22	22	6	74.6	11.2	11.2	3.0
1)	A library program to deliver books (electronically connect) to people who are homebound.	117	26	44	10	59.4	13.2	22.3	5.1
5)	Discounts for elders who want to take classes at local colleges or universities.	110	11	53	23	55.8	5.6	26.9	11.7
2)	Bilingual classes for non-English speaking older adults.	52	11	108	26	26.4	5.6	54.8	13.2
	Overall response	1118	101	281					
		74.5	6.7	18.7					

Item #	7. Family/Caregiving/Support Networks: My community has...	N = 198				Percent			
		E	D	N	N/A	E	D	N	N/A
1)	Referral services to locate general information about caregiver services.	187	2	9	0	94.4	1.0	4.5	0.0
2)	Caregiver education programs.	135	21	38	4	68.2	10.6	19.2	2.0
5)	Caregiver counseling services.	130	20	42	6	65.7	10.1	21.2	3.0
3)	Caregiver support groups.	122	23	47	6	61.6	11.6	23.7	3.0
4)	Caregiver respite services.	113	24	53	8	57.1	12.1	26.8	4.0
	Overall response	687	90	189					
		71.1	9.3	19.6					

Item #	8. Food and Nutrition: My community has...	N = 197				Percent			
		E	D	N	N/A	E	D	N	N/A
3)	Meal services for elders (e.g., home delivered meals, congregate meal sites, transportation to meal sites).	190	2	5	0	96.4	1.0	2.5	0.0
4)	Places to minimizing hunger/food insecurity (e.g., identifying places to buy affordable food; local food banks or pantries).	169	9	16	3	85.8	4.6	8.1	1.5
1)	A farmers' market or other means of access to fresh food.	141	9	42	5	71.6	4.6	21.3	2.5
2)	Assistance in meal preparation (e.g., how to prepare healthy meals and snacks).	92	26	70	9	46.7	13.2	35.5	4.6
5)	Nutrition education classes specifically for elders and adults with disabilities.	92	29	67	9	46.7	14.7	34.0	4.6
	Overall response	684	75	200					
		71.3	7.8	20.9					

Item #	9. Financial Security (money and finances): My community provides...	N = 198				Percent			
		E	D	N	N/A	E	D	N	N/A
3)	Education and information about financial fraud and predatory lending.	176	11	8	3	88.9	5.6	4.0	1.5
5)	Fuel oil or other financial assistance for heating.	176	3	12	7	88.9	1.5	6.1	3.5
7)	Assistance for elders in preparing and filing taxes.	174	6	15	3	87.9	3.0	7.6	1.5
1)	Assistance with basic needs such as a food or clothing pantry.	170	3	22	3	85.9	1.5	11.1	1.5
6)	Property tax relief for elders with limited incomes.	280	9	29	3	85.9	4.0	9.1	1.0
2)	Discount options for transportation services.	153	5	35	5	77.3	2.5	17.7	2.5
4)	Financial assistance for residents in emergency situations.	127	24	37	10	64.1	12.1	18.7	5.1
	Overall response	1256	61	158					
		85.2	4.1	10.7					

Item #	10. Health Care: My community has/hold...	N = 197				Percent			
		E	D	N	N/A	E	D	N	N/A
11)	Preventative immunizations such as influenza and pneumonia.	188	2	3	4	95.4	1.0	1.5	2.0
12)	Health education programs on topics important to elders.	179	6	10	2	90.9	3.0	5.1	1.0
5)	At least one dentist per 2,500 residents serving residents (of all ages).	141	2	40	14	71.6	1.0	20.3	7.1
9)	Free preventive screenings such as mammogram, hearing, vision, PSA, bone density and blood pressure checks.	140	5	48	4	71.1	2.5	24.4	2.0
13)	Health fairs that provide information and screenings for seniors on a regular basis.	130	26	32	9	66.0	13.2	16.2	4.6
6)	At least one primary care physician per 1,000 residents (of all ages).	122	3	48	24	61.9	1.5	24.4	12.2
8)	Diagnostic services such as x-ray, hearing, and vision in the community.	117	1	68	11	59.4	0.5	34.5	5.6
10)	Medication management services or programs.	111	15	59	12	56.3	7.6	29.9	6.1
7)	Chronic disease self-management educational programs.	103	18	68	8	52.3	9.1	34.5	4.1
1)	A hospital or medical center in the community.	100	0	86	11	50.8	0.0	43.7	5.6
3)	A pharmacy that is accessible 24 hours a day/seven days a week.	75	5	99	18	38.1	2.5	50.3	9.1
2)	A minor emergency care center such as a walk-in clinic in the community.	71	4	108	14	36.0	2.0	54.8	7.1
4)	An emergency room in the community.	66	2	114	15	33.5	1.0	57.9	7.6
	Overall response	1543	89	783					
		63.9	3.7	32.4					

Item #	11. Housing and Home Ownership: My community has...	N = 197				Percent			
		E	D	N	N/A	E	D	N	N/A
8)	Subsidized housing facilities.	165	2	25	5	83.8	1.0	12.7	2.5
6)	Assistance in home weatherization.	131	18	37	11	66.5	9.1	18.8	5.6
4)	An adequate number of licensed contractors who do interior and exterior modifications to home (e.g., grab bars, ramps).	108	29	41	19	54.8	14.7	20.8	9.6
2)	A program or service to assist community members of limited means with interior and exterior modifications to homes.	86	26	73	12	43.7	13.2	37.1	6.1
5)	Assessments to help elders identify opportunities to modify their homes for better function and safety.	69	34	82	12	35.0	17.3	41.6	6.1
1)	A community housing assessment completed in the past three years that projects future housing needs for various populations.	66	50	60	21	33.3	25.4	30.5	10.7
3)	A service to mediate between elders and contractors when there are problems.	44	17	122	14	22.3	8.6	61.9	7.1
7)	Modification of municipal services for elders such as backyard trash collection.	29	20	124	24	14.7	10.2	62.9	12.2
	Overall response	698	196	564					
		47.9	13.4	38.7					

Item #	12. Legal Assistance: My community has...	N = 195				Percent			
		E	D	N	N/A	E	D	N	N/A
3)	Programs or seminars on legal issues of interest to elders.	170	6	18	1	87.2	3.1	9.2	0.5
1)	Low or no-cost legal services specializing in the needs of elders.	140	5	46	4	71.8	2.6	23.6	2.1
2)	Assistance for elders in preparing legal documents including wills, trusts, advance care plans, power of attorney.	128	15	46	6	65.6	7.7	23.6	3.1
	Overall response	438	26	110					
		76.3	4.5	19.2					

Item #	13. Leisure and Recreational Activities: My community has...	N = 197				Percent			
		E	D	N	N/A	E	D	N	N/A
3)	Community-sponsored events that promote social interactions such as drop in centers, picnics, etc.	177	4	13	3	89.8	2.0	6.6	1.5
10)	Indoor/outdoor courts for games such as tennis, basketball, racket ball, etc.	151	4	35	7	76.6	2.0	17.8	3.6
12)	Parks and other exercise venues accessible through several modes of mobility.	145	9	40	3	73.6	4.6	20.3	1.5
11)	Outdoor recreational facilities for boating, canoeing, fishing, etc.	144	5	39	9	73.1	2.5	19.8	4.6
5)	Discounted elder prices at local attractions.	137	8	34	18	69.5	4.1	17.3	9.1
2)	An inventory of parks/recreation/sports opportunities complied for the community & available to the public.	132	11	46	8	67.0	5.6	23.4	4.1
9)	Golf courses.	129	1	59	8	65.5	0.5	29.9	4.1
4)	Cultural opportunities that reflect the ethnic demographics of your community.	125	10	49	13	63.5	5.1	24.9	6.6
13)	A facility built or renovated specifically for elders to participate in leisure and recreational activities.	118	16	59	4	59.9	8.1	29.9	2.0
7)	Bicycling trails.	112	13	59	13	56.9	6.6	29.9	6.6
8)	Community gardening.	85	10	91	11	43.1	5.1	46.2	5.6
6)	A swimming pool.	79	2	102	14	40.1	1.0	51.8	7.1
1)	A café society site for elders.	60	13	112	12	30.5	6.6	56.9	6.1
	Overall response	1594	106	738					
		65.4	4.3	30.3					

Item #	14. Long-term care: My community has/provides...	N = 197				Percent			
		E	D	N	N/A	E	D	N	N/A
8)	Routine vaccinations against influenza and pneumococcal disease.	190	3	4	0	96.4	1.5	2.0	
6)	Coordination of care services (e.g., case managers) to enable elders to remain in their homes.	157	13	19	8	79.7	6.6	9.6	4.1
1)	Informational sessions about planning for long-term care.	147	21	21	8	74.6	10.7	10.7	4.1
3)	Hospice care.	143	9	40	5	72.6	4.6	20.3	2.5
7)	Routine podiatry screenings especially for people with diabetes.	136	11	46	4	69.0	5.6	23.4	2
5)	Long-term care options in housing facilities or in the elder's home.	124	28	33	12	62.9	14.2	16.8	6.1
9)	Consumers/residents access to long-term care and supports through a single agency.	121	21	44	11	61.4	10.7	22.3	5.6
2)	Adult day services or other facilities designed especially for those with dementia or AD.	92	12	86	7	46.7	6.1	43.7	3.6
4)	Consumer-directed models of care, that is, consumers determine what types of services they will receive and the manner in which they receive them.	83	26	72	16	42.1	13.2	36.5	8.1
10)	Programs to reduce the prevalence of obesity among older adults.	58	22	103	14	29.4	11.2	52.3	7.1
11)	Programs to reduce chronic lower respiratory diseases.	37	25	121	14	18.8	12.7	61.4	7.1
	Overall response	1288	191	589					
		62.3	9.2	28.5					

Item #	15. Mental Health: My community has...	N = 196				Percent			
		E	D	N	N/A	E	D	N	N/A
8)	Programs available for elders on grief and bereavement.	130	17	47	2	66.3	8.7	24.0	1.0
1)	Alcohol and substance abuse treatment services in the community.	111	1	80	4	56.6	0.5	40.8	2.0
7)	Programs available for elders on depression.	98	18	75	5	50.0	9.2	38.3	2.6
6)	Out-patient mental health counselors available to residents.	90	9	85	12	45.9	4.6	43.4	6.1
3)	Linkages between mental health and primary care organizations.	85	22	78	11	43.4	11.2	39.8	5.6
4)	Mental health counselors specializing in geriatric mental health.	77	13	96	10	39.3	6.6	49.0	5.1
2)	In-patient psychiatric services in the community.	63	3	120	10	32.1	1.5	61.2	5.1
5)	Mental health counselors with expertise in providing services to cultural and linguistic minorities.	45	17	109	25	23.0	8.7	55.6	12.8
	Overall response	699	100	690					
		46.9	6.7	46.3					

Item #	16. Physical Activity, Fitness and Falls Prevention: My community has...	N = 195				Percent			
		E	D	N	N/A	E	D	N	N/A
1)	Exercise and wellness programs specifically tailored to elders.	178	1	12	4	91.3	0.5	6.2	2.1
5)	Walking and jogging trails.	155	4	32	4	79.5	2.1	16.4	2.1
3)	Parks and other exercise venues accessible through several model of mobility.	135	14	38	8	69.2	7.2	19.5	4.1
2)	Community-sponsored events that promote physical activity such as public walks, biking events, etc.	128	17	44	6	65.6	8.7	22.6	3.1
4)	A program that actively focuses on preventing falls and other injuries.	105	39	43	8	53.8	20	22.1	4.1
	Overall response	701	75	169					
		74.2	7.9	17.9					

Item #	17. Safety and Security: My community has...	N = 196				Percent			
		E	D	N	N/A	E	D	N	N/A
4)	A system for elder abuse/neglect/fraud identification and prevention.	145	20	27	4	74.0	10.2	13.8	2.0
1)	A program to educate the public about personal safety and security.	143	23	24	6	73.0	11.7	12.2	3.1
3)	A service for checking up on elders living alone by telephone.	134	20	39	3	68.4	10.2	19.9	1.5
8)	Smoke detectors and batteries offered free for elders, including installation.	110	23	58	5	56.1	11.7	29.6	2.6
9)	Training for law enforcement, fire department and EMT personnel on how to be sensitive to needs of elders.	102	36	49	9	52.0	18.4	25.0	4.6
2)	A program to provide emergency cell phones to elders who need them.	101	18	70	7	51.5	9.2	35.7	3.6
5)	Free, in-home safety checks for elders.	99	28	64	5	50.5	14.3	32.7	2.6
7)	Plans for evacuation of homebound persons or elders in the event of a natural disaster or homeland security threat.	95	72	26	3	48.5	36.7	13.3	1.5
6)	Neighborhood watch programs.	71	23	83	19	36.2	11.7	42.3	9.7
	Overall response	1000	263	440					
		58.7	15.4	25.8					

Item #	18. Spirituality: My community has...	N = 194				Percent			
		E	D	N	N/A	E	D	N	N/A
1)	Faith-based organizations active in helping elders, such as family counseling, preventing isolation, etc.	133	22	31	8	68.6	11.3	16.0	4.1
3)	Faith-based organizations with activities specifically for their elder members.	102	23	50	19	52.6	11.9	25.8	9.8
4)	Faith-based organizations that support and participate in the senior care network.	97	22	58	17	50.0	11.3	29.9	8.8
2)	Faith-based organizations that provide transportation to services and activities.	83	18	81	12	42.8	9.3	41.8	6.2
	Overall response	415	85	220					
		57.6	11.8	30.6					

Item #	19. Transportation System: My community has...	N = 195				Percent			
		E	D	N	N/A	E	D	N	N/A
3)	Dial-a-ride and door-to-door paratransit options.	145	3	38	9	74.4	1.5	19.5	4.6
1)	A public transportation system or coverage by a regional transportation authority.	140	4	49	2	71.8	2.1	25.1	1.0
6)	Nearby access to out-of-town travel options such as air, bus, and train.	111	7	68	9	56.9	3.6	34.9	4.6
8)	Public transportation to major shopping/service areas, senior centers, adult day services, faith communities, and cultural events.	108	8	64	15	55.4	4.1	32.8	7.7
2)	Clearly-marked public transportation stops.	90	8	78	19	46.2	4.1	40.0	9.7
5)	Easy-to-obtain, easily-legible information on public transportation routes and schedules available in multiple languages.	86	9	75	25	44.1	4.6	38.5	12.8
7)	Public transportation on holidays/weekends.	69	7	103	16	35.4	3.6	52.8	8.2
4)	Discounted taxi cab fares for elders.	52	8	117	18	26.7	4.1	60.0	9.2
9)	Shelters, places to sit, and lighting at most public transportation stops.	51	9	104	31	26.2	4.6	53.3	15.9
10)	A comprehensive land-use plan coordinated with transportation planning.	38	33	95	29	19.5	16.9	48.7	14.9
	Overall response	890	96	791					
		50.1	5.4	44.5					

Item #	20. Volunteer Opportunities/Civic Engagement: My community has...	N = 195				Percent			
		E	D	N	N/A	E	D	N	N/A
7)	Transportation to the polls for elders on Election Day.	157	10	27	1	80.5	5.1	13.8	0.5
3)	A range of opportunities for elders who want to volunteer.	148	25	20	2	75.9	12.8	10.3	1
5)	Intergenerational volunteer opportunities.	147	20	25	3	75.4	10.3	12.8	1.5
6)	Opportunities for older adults to serve as mentors or share their expertise	110	30	48	7	56.4	15.4	24.6	3.6
2)	A program or clearinghouse to help elders identify volunteer opportunities.	95	27	68	5	48.7	13.8	34.9	2.6
4)	A Service Corps of Retired Executives (SCORE) program.	28	5	147	15	14.4	2.6	75.4	7.7
1)	A leadership development program for elders that helps them learn skills and tools to enable them to participate more effectively as leaders in the community.	27	29	129	10	13.8	14.9	66.2	5.1
	Overall response	712	146	464					
		53.9	11.0	35.1					

Appendix E

Table GP_2

Socio-Demographic Characteristics

Areas Agency on Aging	Frequency	Percent
BayPath	9	1.7
Bristol	14	2.7
Central Mass	54	10.4
CRW	6	1.2
Coastline	34	6.5
Boston	10	1.9
Berkshire	17	3.3
Cape Cod & Islands	113	21.7
Merrimack	53	10.2
Franklin	20	3.8
Greater Lynn	8	1.5
Greater Springfield	3	0.6
HESSCO	20	3.8
Highland	7	1.3
Minuteman	17	3.3
Mystic Valley	15	2.9
North Shore	5	1.0
Old Colony	28	5.4
Senior care	8	1.5
Somerville-Cambridge	7	1.3
South Shore	14	2.7
Springwell	26	5.0
WestMass	13	2.5
Out of state	12	2.3
Unspecified	8	1.5
Total	521	100.0

2. Gender

Age Range	2005-2007 ACS*				
	Male		Female		Gender
	Estimate	Percent	Estimate	Percent	Estimate
18 - 59 Year Old	1,885,184	49.2	1,943,735	50.8	3,828,919
60 Years and Over	492,826	42.4	668,939	57.6	1,161,765
Total	2,378,010	47.6	2,612,674	52.4	4,990,684

*US Census Bureau, 2005-2007 American Community Survey (ACS) 3-Year Estimate, Table B01001 Sex by Age for Massachusetts.

Age Range	Survey				
	Male		Female		Total
	N	Percent	N	Percent	N
18 - 59 Year Old	27	13.1	179	86.9	206
60 Years and Over	94	31.1	208	68.9	302
Total	121	23.8	387	76.2	508

3a. Race

Race	Under 60		60+		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
One race	204	99.0	292	97.7	496	98.2
White	191	93.6	285	97.6	476	96.0
Black/African-American	9	4.4	4	1.4	13	2.6
American Indian/Alaska Native	1	0.5	2	0.7	3	0.6
Asian	3	1.5	1	0.3	4	0.8
Some other race		0.0		0.0		
Multi-racial/other	2	1.0	7	2.3	9	1.8
Total	206	100.0	299	100.0	505	100.0

3b. Are you of Spanish, Hispanic, or Latino heritage?

Spanish/Hispanic or Latino heritage	Under 60		60+		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes, S/H/L heritage	2	1.0	1	0.4	3	0.6
No, S/H/L heritage	189	99.0	284	99.6	496	99.4
Total	191	100.0	285	100.0	499	100.0

60 and Over			
2005-2007 ACS*			Survey of Elder Needs
Total MA Population	**1,161,765**	**+/-3,984**	
	Percent	MOE	Percent
One race	99.5	+/-0.1	97.7
White	91.9	+/-0.1	97.6
Black or African American	3.5	+/-0.1	1.4
American Indian and Alaska Native	0.2	+/-0.1	0.7
Asian	2.4	+/-0.1	0.3
Native Hawaiian and Other Pacific Islander	0.0	+/-0.1	0.0
Some other race	1.4	+/-0.1	0.0
Two or more races	0.5	+/-0.1	2.3
Hispanic or Latino origin (of any race)	2.8	+/-0.1	0.3
White alone, not Hispanic or Latino	90.5	+/-0.1	99.6

*Source: U.S. Census Bureau, 2005-2007 American Community Survey, B01001. SEX BY AGE - Universe: Total Population

4. Which best portrays your age group?

Age Gp	Age Range	2005-2007 ACS				Survey of Elder Service Needs			
		Estimate	Percent	Estimate	Percent	N	Percent	Frequency	Percent
Under 60	18-34	1,459,556	29.2	3,828,919	76.7	31	6.0	208	40.5
	35-39	473820	9.5			10	1.9		
	40-44	520216	10.4			19	3.7		
	45-49	516799	10.4			29	5.7		
	50-54	458288	9.2			54	10.5		
	55-59	400240	8.0			65	12.7		
60 and Over	60-64	305,290	6.1	1,161,765	23.3	122	23.8	305	59.5
	65-69	219,702	4.4			81	15.8		
	70-74	191823	3.8			35	6.8		
	75-59	169103	3.4			31	6.0		
	80-84	139672	2.8			23	4.5		
	85+	136175	2.7			13	2.5		
	Total	4,990,684		4,990,684	100.0	513	100.0	513	100.0

Source: US Census Bureau, 2005-2007 American Community Survey 3-Year Estimates, Table B01001. Sex by Age

5. Which best portrays your employment status?

Employment Status	18 - 59 Years Old				60 Years and Older			
	2005-2007 ACS*		Survey		2005-2007 ACS*		Survey	
In Civilian labor force:	N	%	N	%	N	%	N	%
Employed	2,940,029	73.5	199	96.1	128,997	10.7	158	52.1
Unemployed	198,093	5.0	3	1.4	185,458	15.3	16	5.3
Not in labor force	861,318	21.5	5	2.4	894,384	74.0	129	42.6
Total	3,999,440	100.0	207	100.0	1,208,839	100.0	303	100.0

*U.S. Census Bureau, 2005-2007 American Community Survey (ACS), Table 23001: Sex by Age by Employment Status for Population 16 Years and Over - Universe: Population 16 Years and Over

Employment Status	Under 60		60 and Over		All Respondents	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Work 35 or more hrs p/wk	172	83.1	100	33.0	272	53.3
Work between 20-35 hrs p/wk	19	9.2	36	11.9	55	10.8
Work less than 20 hrs p/wk	8	3.9	22	7.3	30	5.9
Looking, currently unemployed	3	1.4	16	5.3	19	3.7
Retired/not in labor market	5	2.4	129	42.6	134	26.3
Total	207	100.0	303	100.0	510	100.0

6. Which best portrays your housing status?

Housing Status	Under 60		60 and over		Total	
	N	Percent	N	Percent	N	Percent
Home owner	159	76.4	262	86.5	421	82.4
Renter	43	20.7	29	9.6	72	14.1
Other	6	2.9	12	4.0	18	3.5
	208	100.0	303	100.0	511	100

Population 60 Years and Over in the United States, Massachusetts

Housing	Total	MOE	60 Years and Over	MOE
Occupied housing units	2,448,608	+/-5,235	701,905	+/-4,077
HOUSING TENURE				
Owner-occupied housing units	65.00%	+/-0.3	72.2%	+/-0.4
Renter-occupied housing units	35.00%	+/-0.3	27.8%	+/-0.4

Source: American Community Survey, 2005-2007 ACS 3-Year Estimates, Table S0102. Population 60 Years and Over in the US, Massachusetts

7. & 8. Based on the number of people in your household, which best portrays your total annual household income?

Total Annual Household Income by Survey Respondent s

Household size	2008 Poverty Level Guidelines					
	Below 100%	100% to 200%	200% to 300%	300% to 400%	At or above 400%	Total
1 person	5	26	16	14	40	101
2 persons	5	14	25	40	134	218
3 persons		11	17	4	29	61
4 persons		5	6	8	16	35
5+ persons		4	5	1	2	12
	10	60	69	67	221	427
	2.3%	14.1%	16.2%	15.7%	51.8%	100.0%

*2008 Poverty Level Guidelines For the 48 Contiguous States and DC; Federal Register/Vol. 73.No.15/Wednesday, January 23, 2008.

Total Annual Household Income By Age G roups

Household size	2008 Poverty Level Guidelines											
	Below 100%		100% to 200%		200% to 300%		300% to 400%		At or above 400%		Total	
	Under 60	60 & Over	Under 60	60 & Over	Under 60	60 & Over	Under 60	60 & Over	Under 60	60 & Over	Under 60	60 & Over
1 person	0	5	2	24	4	12	4	10	12	28	22	79
2 persons	1	4	1	13	3	22	11	29	47	87	63	155
3 persons			6	5	12	5	2	2	23	6	43	18
4 persons			5	0	5	1	7	1	13	3	30	5
5+ persons			4	0	4	1	1	0	1	1	10	2
Total	1	9	18	42	28	41	25	42	96	125	168	259
	0.6%	3.5%	10.7%	16.2%	16.7%	15.8%	14.9%	16.2%	57.1%	48.3%	100.0%	100.0%

9.a Caregiver providing informal care for another (n=130)

Informal Caregiver for Another	Under 60	60+	Total
Mother (stepmother)	27	18	45
Spouse	3	17	20
Father (stepfather)	13	5	18
Friend/neighbor/other	8	8	16
In-Law relation	4	7	11
Sibling	3	4	7
Grandparent	3	1	4
Grandchild	0	3	3
Significant other/domestic partner	0	0	0
Unspecified	3	3	6
	64	66	130

Caregiver providing informal care to more than one person (n=58)

Informal caregiving	Under 60	60+	Total
Spouse, Father & Mother	1		1
Spouse & Mother		1	1
Spouse & Grandchild	1	1	2
Spouse, In-law relation & FNO	1		1
Significant other/domestic partner & FNO	1		1
Father, Mother, In-law relation & FNO	1		1
Father, Mother & In-law relation	2		2
Father, Mother & FNO	2	1	3
Father & Mother	10	1	11
Father & Sibling	1		1
Mother & Grandchild		1	1
Mother, Sibling & FNO	1		1
Mother & Sibling		1	1
Mother, In-law relation & FNO	1		1
Mother & In-law relation	2		2
Mother & FNO	1		1
Mother (stepmother)		2	2
Sibling & In-law relation		1	1
Grandparent & FNO	1		1
Grandparents	2		2
Grandchild & In-law relation	1	1	2
Grandchild & FNO	1	1	2
Grandchildren	1	2	3
In-law relation & FNO		1	1
In-law relation	3	1	4
FNO	3	2	5
Unspecified	3	1	4
	40	18	58

Father includes stepfather.
Mother includes stepmother.
FNO = Friend/neighbor/other

Table GP_3a
Part I — Service Needs By Age groups

Sixteen areas of need are listed and are based on previously administered surveys completed by elders. Would you kindly tell us in which areas you need assistance? Please indicate **up to three areas** and by **priority order**.

Item	Area	Under 60 (n=208)								60 & Over (n=305)								All Respondents N=513		
		1st Priority		2nd Priority		3rd Priority		Total		1st Priority		2nd Priority		3rd Priority		Total				
		N	WV=3	N	WV=2	N	WV=1	TR	TWR	N	WV=3	N	WV=2	N	WV=1	TR	TWR	TR	TWR	R
F	Health care	22	66	18	36	12	12	52	**114**	47	141	22	44	12	12	81	**197**	133	**311**	**1**
D	Financial security (money/finances)	15	45	15	30	13	13	43	88	34	102	32	64	18	18	84	**184**	127	**272**	**2**
K	Maintain independence and dignity	20	60	11	22	12	12	43	94	30	90	15	30	33	33	78	**153**	121	**247**	**3**
C	Family/caregiving/support networks	25	75	24	48	20	20	69	**143**	17	51	19	38	11	11	47	100	116	243	
O	Transportation/personal mobility	19	57	18	36	17	17	54	**110**	21	63	18	36	29	29	68	128	122	238	
G	Housing and home ownership	8	24	13	26	15	15	36	65	10	30	27	54	14	14	51	98	87	163	
L	Mental health	10	30	13	26	15	15	38	71	8	24	12	24	5	5	25	53	63	124	
J	Long term care	10	30	8	16	12	12	30	58	9	27	12	24	13	13	34	64	64	122	
I	Leisure, recreation and fitness	3	9	8	16	7	7	18	32	13	39	12	24	23	23	48	86	66	118	
E	Food and nutrition	9	27	14	28	4	4	27	59	8	24	9	18	10	10	27	52	54	111	
M	Safety and security	4	12	3	6	4	4	11	22	9	27	20	40	11	11	40	78	51	100	
A	Career/employment	8	24	3	6	4	4	15	34	15	45	3	6	5	5	23	56	38	90	
B	Education/learning	6	18	4	8	2	2	12	28	7	21	2	4	10	10	19	35	31	63	
P	Volunteer/civic engagement	2	6	0	0	6	6	8	12	3	9	6	12	14	14	23	35	31	47	
H	Legal assistance	3	9	4	8	7	7	14	24	0	0	6	12	5	5	11	17	25	41	
N	Spirituality	0	0	1	2	1	1	2	3	2	6	2	4	3	3	7	13	9	16	

WV= Weighted value

R = Rank

TR = Total raw responses

TWR = Weighted responses

Table GP_3b

Part I — Service Needs by Cape Cod and non-Cape Cod Respondents

Item	Area	22 AAAs Respondents								Single AAA Respondents								All Respondents		
		1st Priority		2nd Priority		3rd Priority		n=399		1st Priority		2nd Priority		3rd Priority		n=111		N=513		
		N	WV=3	N	WV=2	N	WV=1	N	TWR	N	WV=3	N	WV=2	N	WV=1	N	TWR	TR	TWR	R
F	Health care	51	153	31	62	18	18	100	**233**	18	54	9	18	6	6	33	**78**	133	**311**	**1**
D	Financial security (money/finances)	35	105	37	74	25	25	97	**204**	14	42	10	20	6	6	30	**68**	127	**272**	**2**
K	Maintain independence and dignity	41	123	20	40	34	34	95	197	9	27	6	12	11	11	26	50	121	**247**	**3**
C	Family/caregiving/support networks	37	111	39	78	27	27	103	**216**	5	15	4	8	4	4	13	27	116	243	
O	Transportation/personal mobility	36	108	30	60	35	35	101	203	4	12	6	12	11	11	21	35	122	238	
G	Housing and home ownership	14	42	30	60	23	23	67	125	4	12	10	20	6	6	20	38	87	163	
L	Mental health	18	54	23	46	19	19	60	119	0	0	2	4	1	1	3	5	63	124	
J	Long term care	15	45	18	36	20	20	53	101	4	12	2	4	5	5	11	21	64	122	
I	Leisure, recreation and fitness	6	18	12	24	18	18	36	60	10	30	8	16	12	12	30	**58**	66	118	
E	Food and nutrition	16	48	17	34	14	14	47	96	1	3	6	12	0	0	7	15	54	111	
M	Safety and security	10	30	16	32	12	12	38	74	3	9	7	14	3	3	13	26	51	100	
A	Career/employment	15	45	5	10	6	6	26	61	8	24	1	2	3	3	12	29	38	90	
B	Education/learning	10	30	4	8	9	9	23	47	3	9	2	4	3	3	8	16	31	63	
P	Volunteer/civic engagement	5	15	2	4	13	13	20	32	0	0	4	8	7	7	11	15	31	47	
H	Legal assistance	3	9	9	18	11	11	23	38	0	0	1	2	1	1	2	3	25	41	
N	Spirituality	1	3	1	2	3	3	5	8	1	3	2	4	1	1	4	8	10	16	

WV= Weighted value

R = Rank

TR = Total raw responses

TWR = Weighted responses

Table GP_4a
Specific Service Needs Within Each Area (N-513)

Item #	**F**. Regarding "**health care**," my specific needs include: (Check all that apply.)	N=139	
1	affording health insurance.	89	64.0%
4	paying for out-of-pocket health care costs.	81	58.3%
2	understanding my health insurance plan and health care system.	71	51.1%
6	affording and/or managing my medications.	67	48.2%
12	help with getting and paying for dental care.	52	37.4%
10	dealing with chronic physical conditions (e.g., diabetes and high blood pressure).	47	33.8%
13	help with getting glasses and paying for vision care.	40	28.8%
9	dealing with cognitive impairment illnesses such as Alzheimer's Disease.	32	23.0%
14	help with getting and paying for a hearing aid.	32	23.0%
3	finding screening and immunization programs.	26	18.7%
11	learning about health & wellness programs including injury prevention.	25	18.0%
15	accessing non-traditional medical services.	25	18.0%
7	having someone help me appeal or resolve medical charges.	23	16.5%
5	finding culturally and/or linguistically sensitive hea lth care workers.	13	9.4%
8	dealing with alcohol, drug and tobacco related illness.	7	5.0%
16	other (write in)	14	10.1%
Item #	**D.** Regarding "**financial security (money/finances)**," my specific needs include: (Check all that apply.)	N=131	
3	help with housing expenses such as mortgage, utilities and home repairs.	79	60.3%
4	help with health, medical or medication costs such as co payments.	79	60.3%
12	how to protect my money, assets or property.	66	50.4%
9	ways to improve my financial situation.	65	49.6%
8	learning about local tax/fee relief programs for elders.	58	44.3%
1	securing government benefits that I may be eligible for such as Food Stamps or Supplemental Nutrition Assistance Program.	49	37.4%
10	understanding my insurance policies su ch as health and home owner's insurance.	42	32.1%
11	ways to save and invest my money.	36	27.5%
5	help with transportation expenses such as gas and vehicle maintenance.	34	26.0%
6	help with managing debt such as credit card bills.	33	25.2%
2	learning ways to be a "smart shopper" or better consumer.	29	22.1%
7	help with preparing my taxes.	23	17.6%
13	other (write in)	9	6.9%
Item #	**K.** Regarding "**maintain independence/dignity**," my specific needs include: (Check all that apply.)	N=123	
3	adapting my home to my changing health or physical needs.	64	52.0%
1	getting my financial house in order so I can remain lifelong in my home.	62	50.4%
8	having accessible and convenient public transportation options.	61	49.6%
11	maintaining social connectio n with others.	61	49.6%
2	securing resources to supplement my income to meet basic needs.	46	37.4%
9	having walkable access to shops, parks and leisure activities along with well maintained streets and sidewalks.	44	35.8%
4	learning about life style changes to maintain mental/physical well being.	43	35.0%
10	learning about warning signs of unsafe driving/adjusting to life without driving.	40	32.5%
7	learning about long-term care options including long-term insurance.	38	30.9%

13	having affordable housing options in a safe and secure community.	37	30.1%
14	learning about volunteer/ civic opportunities in my community.	28	22.8%
6	planning for end-of-life care such as selecting a hospice program.	20	16.3%
12	finding part time or full time employment.	13	10.6%
5	help to resolve a discriminatory practice such as age or sexual orientation matters.	5	4.1%
15	other (write in)	4	3.3%
Item #	**C**. Regarding "**family/caregiving/support networks**," my specific needs include: (Check all that apply.)	N=119	
1	how to prepare for my or family member's long-term care.	70	58.8%
2	finding reputable providers of home care services.	64	53.8%
3	obtaining general information about caregiving and caregiver services.	58	48.7%
4	finding caregivers to help me.	50	42.0%
11	help balancing my work and caregiving responsibilities.	50	42.0%
10	help with paying for my care recipient's caregiving needs.	41	34.5%
9	help with paying for my caregiving needs.	38	31.9%
7	obtaining respite services (a break from caregiving).	36	30.3%
12	learning how to manage my time and caregiving responsibilities.	35	29.4%
5	locating or securing a support group.	24	20.2%
6	finding counseling services.	24	20.2%
8	finding a structured day program such as adult day care.	20	16.8%
13	other (write in)	6	5.0%
Item #	**O.** Regarding "**transportation/personal mobility**," my specific needs include: (Check all that apply.)	N=123	
6	ability to have pickup appointments on short notice; not days in advance.	82	66.7%
3	finding escort services for medical and other appointments.	72	58.5%
5	having non-medical paratransit services, that is, passenger transportation with no fixed routes or schedules.	70	56.9%
1	learning about transportation programs for elders/adults with disabilities.	65	52.8%
4	help with defraying transportation costs.	50	40.7%
13	getting assistive devices to help me remain mobile in my home/outside.	45	36.6%
2	getting handicapped accessible transportation services.	37	30.1%
8	having benches placed in the community to allow people with physical disabilities to rest.	33	26.8%
10	having injury-free side walks (including adequate street lights) and walking paths.	33	26.8%
9	having cross walk timers installed with ample time to cross the streets.	32	26.0%
7	having rest areas at public transportation pickup sites.	28	22.8%
12	help in deciding when to cut back or stop driving.	27	22.0%
11	having larger print street signs.	25	20.3%
14	other (write in)	11	8.9%
Item #	**G.** Regarding "**housing and home ownership**," my specific needs include: (Check all that apply.)	N=87	
1	finding affordable housing.	43	49.4%
7	help with home repairs.	43	49.4%
8	help with property taxes and/or fees.	41	47.1%
9	help with utilities bills.	41	47.1%
4	securing energy assistance such as fuel/heating assistance.	39	44.8%
6	help with home maintenance and chores.	34	39.1%
12	locating "reputable" contractors.	32	36.8%
3	learning about housing options in my community such as senior housing.	29	33.3%
5	adapting my home to meet my changing needs such as installing grab bars.	28	32.2%

2	finding affordable housing that is handicapped accessible.	15	17.2%
10	help making my home/apartment more secure or injury free.	15	17.2%
13	facing foreclosure and getting help to keep my h ome.	9	10.3%
11	getting legal assistance with housing issues.	3	3.4%
14	other (write in)	3	3.4%
Item #	**L.** Regarding "**mental health**," my specific needs include: (Check all that apply.)	N=65	
1	accessing mental health services.	35	53.8%
8	securing services to address depression or suicide.	30	46.2%
5	paying for mental health services.	29	44.6%
9	securing services to address loss, grief or bereavement.	28	43.1%
6	help with balancing caregiving responsibilities and taking care of me.	25	38.5%
11	learning life or coping skills such as working through conflict, stress or anger.	23	35.4%
13	having to combat the ridicule or stigma attached to mental health conditions.	23	35.4%
12	where to go if I need emergency services.	19	29.2%
4	finding approaches to mental health care that do not involve medications.	18	27.7%
10	securing services to address drug/medication misuse or dependency.	16	24.6%
2	finding mental health specialists who speak the same language as me such as the American Sign Language.	11	16.9%
3	finding mental health specialists who understand my ethnic practices and culture.	11	16.9%
7	securing services to address abuse, neglect or exploitation matters.	10	15.4%
14	other (write in)	3	4.6%
Item #	**J.** Regarding **"long-term care,"** my specific needs include: (Check all that apply.)	N=65	
2	learning about ways to pay for long-term care needs.	48	73.8%
1	learning about long-term care option for myself or another.	43	66.2%
5	securing personal care services.	28	43.1%
6	securing homemaker/chore services.	28	43.1%
13	securing transportation services.	19	29.2%
3	securing health-related services.	18	27.7%
10	securing adult day care.	18	27.7%
14	participating in personal activities offered at senior centers.	12	18.5%
9	securing companionship services.	10	15.4%
7	securing social services.	9	13.8%
11	securing case management services.	9	13.8%
12	securing home delivered meals.	9	13.8%
4	securing medication management services.	8	12.3%
8	securing protective services.	1	1.5%
15	other (write in)	5	7.7%
Item #	**I.** Regarding "**leisure, recreation and fitness**," my specific needs include: (Check all that apply.)	N=66	
1	learning about available leisure and recreational opportunities in my community.	44	66.7%
11	participating in physical activities (e.g., dancing, swimming, walking clubs).	43	65.2%
15	finding and engaging in activities that promote flexibility.	32	48.5%
14	finding and engaging in activities that promote strength building.	28	42.4%
9	participating in social activities (e.g., meals with friends, joining clubs).	26	39.4%
2	finding recreational opportunities for elders or disabled adults.	24	36.4%
10	participating in cognitive/mental activities (e.g., bridge, chess, book clubs, and brain games).	23	34.8%
13	finding and engaging in activities that promote balance.	19	28.8%
3	finding recreational opportunities for men.	16	24.2%

8	securing transportation to participate in recreational opportunities.	15	22.7%
12	participating in injury prevention activities (e.g., falls, cuts, poisons).	6	9.1%
4	finding recreational opportunities for veterans.	4	6.1%
5	finding recreational opportunities for culturally specific groups,	3	4.5%
6	finding recreational opportunities for lesbian, gay, bisexual and transsexual (LGBT) persons.	2	3.0%
7	finding recreational opportunities for my adult disabled child(ren).	1	1.5%
16	other (write in)	16	24.2%
Item #	**E.** Regarding "**food and nutrition**," my specific needs include: (Check all that apply.)	N=56	
1	affording groceries.	36	64.3%
2	identifying places to buy nutritious and affordable food.	16	28.6%
4	learning how to prepare healthy meals and snacks.	15	26.8%
9	finding information about home delivered meals.	15	26.8%
10	finding individualized nutrition counseling.	15	26.8%
11	finding general information on good nutrition.	15	26.8%
12	finding information on weight management.	15	26.8%
13	finding information on nutrition to prevent or treat a disease.	15	26.8%
8	finding transportation to meal sites.	14	25.0%
5	learning how to shop for healthy foods.	12	21.4%
3	finding local food banks or pantries.	10	17.9%
6	learning about safe handling of food.	8	14.3%
14	learning about shelf stable food and how much water to stockpile for emergencies.	8	14.3%
15	learning where to store and how to maintain emergency food and water.	7	12.5%
7	finding congregate (group) meals site locations.	5	8.9%
16	other (write in)	1	1.8%
Item #	**M.** Regarding "**safety and security**," my specific needs include: (Check all that apply.)	N=51	
10	learning about injury and accident prevention practices.	33	64.7%
8	having well-maintained, unobstructed sidewalks with visible curb cuts.	29	56.9%
7	having adequate street lighting for pedestrian safety and security.	28	54.9%
9	help in determining when I should cut back or stop driving.	25	49.0%
4	learning about evacuation procedures when a natural/man-made disaster occurs.	23	45.1%
2	recognizing and reporting financial exploitation or fraud.	22	43.1%
11	how I can make my neighborhood safer from crime for myself and elders.	21	41.2%
12	how to get and use assistive technology to get around safety in my home and outside.	16	31.4%
3	recognizing and reporting self-neglect.	9	17.6%
5	learning about which shelf stable food and how much water to stockpile for emergencies.	9	17.6%
6	having litter/trash removed from streets, sidewalks and public spaces in my neighborhood.	8	15.7%
1	recognizing and reporting physical and emotional abuse, neglect and exploitation.	6	11.8%
13	other (write in)	3	5.9%
Item #	**A.** Regarding "**career/employment**" my specific needs include: (Check all that apply.)	N=41	
2	securing part-time employment.	20	48.8%
1	securing full time employment.	15	36.6%
6	securing employment counseling and guidance.	10	24.4%
7	accessing services through the computer.	10	24.4%
5	participating in the Senior Community Service Employment Program.	8	19.5%
3	enrolling in a training or vocational rehabilitation program.	6	14.6%
8	planning for retirement.	6	14.6%
9	talking with someone about my rights under the federal laws prohibiting job discrimination.	6	14.6%

4	finding the Career Center/One Stop in my community.	4	9.8%
10	other (write in)	2	4.9%
Item #	**B.** Regarding "**education/learning**," my specific needs include: (Check all that apply.)	N=31	
1	enrolling in community education programs.	16	51.6%
10	coping with the challenges of aging.	13	41.9%
3	taking courses online.	11	35.5%
13	learning about fitness programs for health and wellness .	11	35.5%
7	preparing for my financial security in life.	10	32.3%
6	becoming more computer literate.	9	29.0%
14	managing better my caregiving responsibilities.	8	25.8%
5	becoming a better consumer of services.	7	22.6%
8	eating healthier.	7	22.6%
9	managing money/bills/claims.	5	16.1%
2	enrolling in a certificate or degree program.	4	12.9%
4	finding classes tailored for elders/adults with disabilities.	4	12.9%
11	preparing for another career or job.	4	12.9%
12	maintaining a safe and injury-free home.	4	12.9%
15	other (write in)	3	9.7%
Item #	**P.** Regarding "**volunteer/civic engagement**," my specific needs include: (Check all that apply.)	N=32	
1	learning about available volunteer opportunities in my community.	24	75.0%
4	learning about my skills or abilities that I can bring to volunteer events.	14	43.8%
2	finding volunteer opportunities specifically for elders and adults with disabilities.	8	25.0%
3	finding how to become a mentor to children.	5	15.6%
5	securing transportation to volunteer events.	3	9.4%
6	other (write in)	2	6.3%
Item #	**H.** Regarding "**legal assistance**," my specific needs include: (Check all that apply.)	N=27	
1	finding affordable legal services.	19	70.4%
5	learning about guardianship.	13	48.1%
2	learning about consumer rights, scams and frauds.	11	40.7%
11	help preparing a will.	10	37.0%
6	help with foreclosure or home ownership matters.	6	22.2%
10	help filing income tax(es).	5	18.5%
9	help dealing with creditors.	4	14.8%
13	appealing the "denied" decision for benefits or coverage.	4	14.8%
3	help with abuse, neglect or exploitation matters by another.	3	11.1%
4	getting guidance on elder self-neglect.	3	11.1%
8	help securing credit.	3	11.1%
7	help with tenant issues.	2	7.4%
12	help with immigration, naturalization or citizenship matters.	0	0.0%
14	___ other (write in)	2	7.4%
Item #	**N.** Regarding "**spirituality**," my specific needs include: (Check all that apply.)	N=10	
7	better integration of spiritual/religious concerns with end-of-life care.	5	50.0%
1	learning more about my spiritual/ religious tradition's views on aging, death, and dying.	4	40.0%
2	learning more about spiritual/religious approaches to coping with loss and grief.	3	30.0%
4	identifying religious/spiritual organizations in my community (e.g., churches, synagogues, mosques, temples, etc.).	3	30.0%
5	securing transportation to religious/spiritual services and events.	3	30.0%

8	more opportunities to discuss spiritual/religious issues with other elders and my family.	3	30.0%
3	learning more about other spiritual/religious traditions.	2	20.0%
6	in-home religious/spiritual services.	1	10.0%
9	other (write in)	1	10.0%

Table GP_5a

Statewide Respondents' Recommended Service Priorities for EOEA by Age Groups

1. From among the listed items, which would you recommend **ELDER AFFAIRS** focus on between now and 2013? **(Select up to any FIVE items.)** If an area of your concern is not listed, please add under Other.

Item #	Service Priorities	Under 60 (n=207)			60 and Over (n=303)			Total (n=510)		
		N	%	R	N	%	R	N	%	R
2	Expand affordable elder housing capacity and support options.	113	12.6	**1**	129	10.3	**2**	242	11.3	**1**
8	Improve access/increase public and paratransit transportation options.	100	11.2	**2**	128	10.2	**3**	228	10.6	**2**
12	Increase home and health care workforce.	93	10.4	**3**	114	9.1	**4**	207	9.7	**3**
7	Promote fitness, exercise and recreational activities including injury/falls prevention programs.	68	7.6		138	11.0	**1**	206	9.6	**4**
14	Establish a single, coordinated system of information and access for all persons seeking long-term supports.	71	7.9		102	8.2		173	8.1	**5**
4	Encourage residents to plan for one's medical and non-medical long-term care.	75	8.4	**5**	83	6.6		158	7.4	
6	Improve access to mental health services including screenings and support programs.	84	9.4	**4**	66	5.3		150	7.0	
5	Promote preventative health including screenings and immunizations.	42	4.7		103	8.2	**5**	145	6.8	
11	Promote social connections and volunteer/civic engagement in the community.	44	4.9		74	5.9		118	5.5	
13	Re-examine the role of senior centers.	35	3.9		77	6.2		112	5.2	
9	Promote personal preparedness planning such as financial security and chronic disease self-management.	42	4.7		64	5.1		106	4.9	
1	Provide additional information regarding elder abuse, fraud, exploitation and elder self neglect.	45	5.0		47	3.8		92	4.3	
10	Encourage employment retention, training/retraining and recruitment of older workers.	30	3.4		60	4.8		90	4.2	
3	Educate residents about degenerative illnesses such as dementia/Alzheimer's Disease.	34	3.8		44	3.5		78	3.6	
15	Other (write in)	19	2.1		21	1.7		40	1.86	

Table GP_5b

Statewide Respondents' Recommended Service Priorities for EOEA by Location

Item #	Service Priorities	Non-Cape (n=399)			Cape Alone (n=111)			Respondents (n=510)		
		N	%	R	N	%	R	N	%	R
2	Expand affordable elder housing capacity and support options.	206	12.3	1	36	7.6		242	11.3	1
8	Improve access/increase public and paratransit transportation options.	179	10.7	2	49	10.3	2	228	10.6	2
12	Increase home and health care workforce.	169	10.1	3	38	8.0	5	207	9.7	3
7	Promote fitness, exercise and recreational activities including injury/falls prevention programs.	146	8.7	4	60	12.7	1	206	9.6	4
14	Establish a single, coordinated system of information and access for all persons seeking long-term supports.	136	8.1	5	37	7.8		173	8.1	5
4	Encourage residents to plan for one's medical and non-medical long-term care.	118	7.1		40	8.4	4	158	7.4	
6	Improve access to mental health services including screenings and support programs.	129	7.7		21	4.4		150	7.0	
5	Promote preventative health including screenings and immunizations.	99	5.9		46	9.7	3	145	6.8	
11	Promote social connections and volunteer/civic engagement in the community.	82	4.9		36	7.6		118	5.5	
13	Re-examine the role of senior centers.	87	5.2		25	5.3		112	5.2	
9	Promote personal preparedness planning such as financial security and chronic disease self-management.	79	4.7		27	5.7		106	4.9	
1	Provide additional information regarding elder abuse, fraud, exploitation and elder self neglect.	78	4.7		14	3.0		92	4.3	
10	Encourage employment retention, training/retraining and recruitment of older workers.	67	4.0		23	4.9		90	4.2	
3	Educate residents about degenerative illnesses such as dementia/Alzheimer's Disease.	62	3.7		16	3.4		78	3.6	
15	Other (write in)	34	2.0		6	1.3		40	1.9	

Table GP_6a
Statewide Respondents' Recommended Service Priorities for Their Communities by Age Group

2. From among the items listed, which would you recommend **YOUR COMMUNITY** to focus on between now and 2013? (**Select up to any FIVE items**.) If an area of your concern is not listed, please add under Other.

Item #	Service Priorities	Under 60 (n=207)			60 & Over (n=303)			Total (n=510)		
		N	%	R	N	%	R	N	%	R
4	Assist elders with home modification, repair and maintenance services.	123	13.5	2	167	13.2	1	290	13.3	1
2	Expand affordable elder housing capacity and support options.	127	13.9	1	129	10.2	2	256	11.8	2
8	Improve access/increase public and paratransit transportation options.	100	11.0	3	128	10.1	3	228	10.5	3
3	Expand options to help elder homeowners with increasing cost of home ownership.	77	8.5	4	128	10.1	3	205	9.4	4
7	Promote fitness, exercise and recreational activities including injury/falls prevention programs.	64	7.0		118	9.3	5	182	8.4	5
5	Promote preventative health care, screenings and immunizations.	45	4.9		99	7.8		144	6.6	
1	Help prepare residents for its aging population.	65	7.1		73	5.8		138	6.3	
6	Improve access to mental health services including screening and support programs.	72	7.9	5	58	4.6		130	6.0	
11	Promote social connections and volunteer/civic engagement in the community.	49	5.4		79	6.2		128	5.9	
13	Re-examine the role of senior centers.	45	4.9		80	6.3		125	5.7	
14	Better planning to reflect residents' vision of "livable" neighborhoods.	53	5.8		57	4.5		110	5.1	
10	Encourage employment retention, training/retraining and recruitment of older workers.	27	3.0		58	4.6		85	3.9	
9	Promote pedestrian and driver safety in community design and planning.	34	3.7		46	3.6		80	3.7	
12	Improve our emergency response capacity.	21	2.3		38	3.0		59	2.7	
15	Other	9	1.0		9	0.7		18	0.8	

Table GP_6b
Statewide Respondents' Recommended Service Priorities for Their Communities by Location

Item #	Service Priorities	Non-Cape Respondents (n=399)			Cape Cod Only (n=111)			Total Respondents (N=510)		
		N	%	R	N	%	R	N	%	R
4	Assist elders with home modification, repair and maintenance services.	228	13.3%	1	62	13.4%	1	290	13.3%	1
2	Expand affordable elder housing capacity and support options.	217	12.6%	2	39	8.4%		256	11.8%	2
8	Improve access/increase public and paratransit transportation options.	184	10.7%	3	44	9.5%	3	228	10.5%	3
3	Expand options to help elder homeowners with increasing cost of home ownership.	160	9.3%	4	45	9.7%	2	205	9.4%	4
7	Promote fitness, exercise and recreational activities including injury/falls prevention programs.	140	8.2%	5	42	9.1%	5	182	8.4%	5
5	Promote preventative health care, screenings and immunizations.	100	5.8%		44	9.5%	3	144	6.6%	
1	Help prepare residents for its aging population.	114	6.6%		24	5.2%		138	6.3%	
6	Improve access to mental health services including screening and support programs.	109	6.4%		21	4.5%		130	6.0%	
11	Promote social connections and volunteer/civic engagement in the community.	91	5.3%		37	8.0%		128	5.9%	
13	Re-examine the role of senior centers.	97	5.7%		28	6.1%		125	5.7%	
14	Better planning to reflect residents' vision of "livable" neighborhoods.	86	5.0%		24	5.2%		110	5.1%	
10	Encourage employment retention, training/retraining and recruitment of older workers.	66	3.8%		19	4.1%		85	3.9%	
9	Promote pedestrian and driver safety in community design and planning.	60	3.5%		20	4.3%		80	3.7%	
12	Improve our emergency response capacity.	50	2.9%		9	1.9%		59	2.7%	
15	Other	14	0.8%		4	0.9%		18	0.8%	

Appendix E: Intra-State Funding Formula and 2010 Allocation Plan

In mirroring the objectives of the Older Americans Act, the Massachusetts Intrastate Funding Formula targets older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income individuals and those living in rural areas. The purpose of the Elder Affairs Intrastate Funding Formula (the formula) is to allocate funds in accord with the proportion of potential clients in each Planning and Service Area (PSA). Special emphasis is given to individuals 60+ with the greatest economic or social needs that are identified by the best demographic data available derived from Elder Affairs' research and Needs Assessment efforts.

Formula Explanation and Methodology

The Executive Office of Elder Affairs distributes Title III funding using the formula when funds available are in excess of each Area Agencies on Aging Federal Fiscal Year 1984 allocation. A "hold harmless" principle is applied in the application of the formula such that no Area Agency on Aging (AAA) will receive an allocation that is less than its Federal Fiscal Year 1984 allocation. The formula is comprised of six basic components that are weighed as to the relative significance of each component within the total formula. The total of the numerical weights for the weighted components of the formula is ten.

Each PSA's formula funding factor is the sum of its individual percent of state totals of the identified population factors times each factor's weight divided by ten. It is applied to available funding to determine AAA allocations.

Specific components of the formula, together with the numerical weight assigned to each, are the following:

Formula Component	Assigned Weight
1. Proportion of persons aged 75 and over in PSA	1.00
2. Proportion of persons living alone aged 60 and over in PSA	1.50
3. Proportion of low income persons aged 60 and over in PSA	4.75
4. Proportion of minority persons aged 65 and over in PSA	2.00
5. Proportion of persons living in rural towns aged 65 and over in PSA	.50
6. Proportion of persons aged 60 and over in PSA	.25

Methodology for using the formula:

Step One — For each Area Agency on Aging:

a. Calculate the 75+ population as a percent of the State's total 75+ population, multiply the results by 1.

b. Calculate the 60+ living alone population as a percent of the State total 60+ living alone population, multiply the result times 1.5.

c. Calculate the 60+ low-income population as a percent of the State's 60+ low-income population, multiply the result times 4.75.

d. Calculate the 65+ minority population as a percent of the State's total 65+ minority population, multiply the result times 2.

e. Calculate the 65+ rural towns population as percent of the State's rural town population, multiply the results times .5.

f. Calculate the 60+ population as a percent of the State's total 60+ population, multiply the results times .25.

g. Add the results of Step One (a) through (f) and divide by 10. This is the formula funding ratio.

Step Two — For each Area Agency on Aging, multiply the funds available for distribution (the amount in excess of the total Federal Fiscal Year 1984 allocation) times each AAA's formula funding ratio.

Step Three — For each Area Agency on Aging; add its Federal Fiscal Year 1984 allocation plus the result of Step Two above. This figure, then, is the Area Agency's current years Title III allocation.

It should be noted that the above formula methodology does not apply to certain categories of program funding under Title III as allocated by Elder Affairs. The exceptions to this formula are:

- The Long Term Care Ombudsman Program (LTCOP) services in Massachusetts are funded from two sources of Older Americans Act funding. Title III -B Supportive Service funding and Title VII Ombudsman funding are combined to form the total available funding under the LTCOP. Additionally, the funding distribution of LTC OP funding to the Area Agencies on Aging in

Massachusetts is rooted in a historical base, with any additional fun ding that may be available, being awarded to the AAA's based on the number of facility beds located in the Planning and Service Area.

- The distribution of Title III-D Health Promotion and Medication Management Program funding is based on a historical basis as well, with its inception dating back to the beginning of the Federal Title III award to Elder Affairs. Additional funding from the Administration on Aging is awarded to the twenty -three AAA's using this formula.

- The funding provided to Elder Affairs for Title III-E Family Caregiver Services Program is distributed to the AAA's in Massachusetts using the Intrastate Funding Formula described above; however, the chief distinction is that the distribution is based solely on the "best demographic data avail able". That is, the distribution of Title III-E funding is calculated using 2000 Census information; the Federal Fiscal Year 1984 base plays no part in the funding allocation under the Title III-E Family Caregiver Services Program.

The following table, "2010 Estimated Allocation Plan", lists the Area Agencies on Aging and their projected Federal Fiscal Year 2010 allocations for services provided under Title III and VII of the Older Americans Act. The table represents the distribution of funding based on the preceding Intrastate Funding Formula methodology submitted for approval to the Administration on Aging, and the distinct funding as outlined above for LTC Ombudsman services, Title III-D Health Promotion and Medication Management services and Title III-E Family Caregiver services.

Formula Modification

Elder Affairs continues to apply the above Intrastate Funding Formula for Federal Fiscal Year 2010. However, viable adjustments to the formula will be initiated over FY2010 that includes a review of the basic methodology in support of the distribution of Title III funding in Massachusetts. It is appropriate at this time to work together with the Area Agencies on Aging in Massachusetts to explore the possibilities for a new approach.

The use of the current formula within the Massachusetts State Plan on Aging, 2010-2013, continues through Federal Fiscal Year 2010. The Executive Office of Elder Affairs will amend the Massachusetts Intrastate Funding Formula within the 2010-2013 State Plan on Aging, at such future time for submission to and approval by the Assistant Secretary on Aging at the Administration on Aging.

COMMONWEALTH OF MASSACHUSETTS - EXECUTIVE OFFICE OF ELDER AFFAIRS

FEDERAL FISCAL YEAR 2010 - ESTIMATED TITLE III RESOURCE ALLOCATION PLAN FOR AREA AGENCY ON AGING SERVICES

AREA PLAN ADMINISTRATION, SUPPORTIVE SERVICES, NUTRITION SERVICES, HEALTH PROMOTION SERVICES, MEDICATION MANAGEMENT SERVICES, FAMILY CAREGIVER SERVICES AND LONG TERM CARE OMBUDSMAN SERVICES

AREA AGENCY ON AGING	AREA PLAN ADMIN	TITLE III - B SUPPORTIVE SERVICES	TITLE III - C NUTRITION SERVICES	TITLE III - D HEALTH PROMOTION SERVICES	TITLE III - D MEDICATION MANAGEMENT SERVICES	TITLE III - E FAMILY CAREGIVER SERVICES	LONG TERM CARE OMBUDSMAN SERVICES	TOTAL TITLE III FUNDING
BAYPATH	$ 110,862	$ 138,335	$ 262,516	$ 7,065	$ 2,502	$ 72,044	$ 64,104	$ 657,428
BERKSHIRE COUNTY	76,420	190,695	352,166	9,461	3,352	100,630	66,688	799,412
BOSTON COMMISSION	315,961	1,101,148	2,027,008	61,358	21,733	485,926	172,876	4,186,010
BRISTOL COUNTY	122,893	297,926	548,625	20,649	7,315	156,921	72,356	1,226,685
CAPE COD & ISLANDS	63,978	275,327	501,910	23,483	8,318	128,046	86,342	1,087,404
CENTRAL MASS	322,639	597,168	1,113,850	31,765	11,253	296,341	270,665	2,643,681
CHELSEA/REVERE/WINTHRO	62,023	127,917	240,552	8,665	3,070	63,585	40,442	546,254
COASTLINE	100,884	233,383	432,818	13,876	4,915	107,629	44,791	938,296
FRANKLIN COUNTY	44,363	155,382	284,452	7,114	2,521	73,210	45,890	612,932
GREATER LYNN	70,773	148,222	276,587	8,661	3,069	79,918	41,299	628,529
GREATER SPRINGFIELD	85,287	343,775	628,584	19,420	6,879	163,339	72,178	1,319,462
HESSCO	45,670	119,026	221,200	5,085	1,800	49,001	47,219	489,001
HIGHLAND VALLEY	42,932	159,406	294,232	8,379	2,968	76,418	44,122	628,457
MERRIMACK VALLEY	152,078	439,195	809,274	25,910	9,179	207,382	127,223	1,770,241
MINUTEMAN	155,380	146,523	284,796	7,613	2,697	74,085	52,480	723,574
MYSTIC VALLEY	114,570	247,315	458,888	14,172	5,021	117,545	-	957,511
NORTH SHORE	44,338	142,552	265,149	5,386	1,908	55,419	122,488	637,240
OLD COLONY P C	164,421	270,447	505,835	15,618	5,533	142,338	114,538	1,218,730
SENIORCARE	30,292	144,870	270,071	4,531	1,605	43,168	45,029	539,566
SOMERVILLE/CAMBRIDGE	106,835	201,302	378,915	9,985	3,538	92,753	39,334	832,662
SOUTH SHORE	115,874	235,726	436,751	11,985	4,247	127,461	66,047	998,091
SPRINGWELL	86,164	292,350	538,401	12,970	4,595	127,754	98,563	1,160,797
WESTMASS ELDERCARE	95,181	184,995	347,710	10,558	3,739	75,838	41,074	759,095
TOTALS	**$ 2,529,818**	**$ 6,192,985**	**$ 11,480,290**	**$ 343,709**	**$ 121,757**	**$ 2,916,751**	**$ 1,775,748**	**$ 25,361,058**

Appendix F: Elder Network, Planning and Service Area Maps

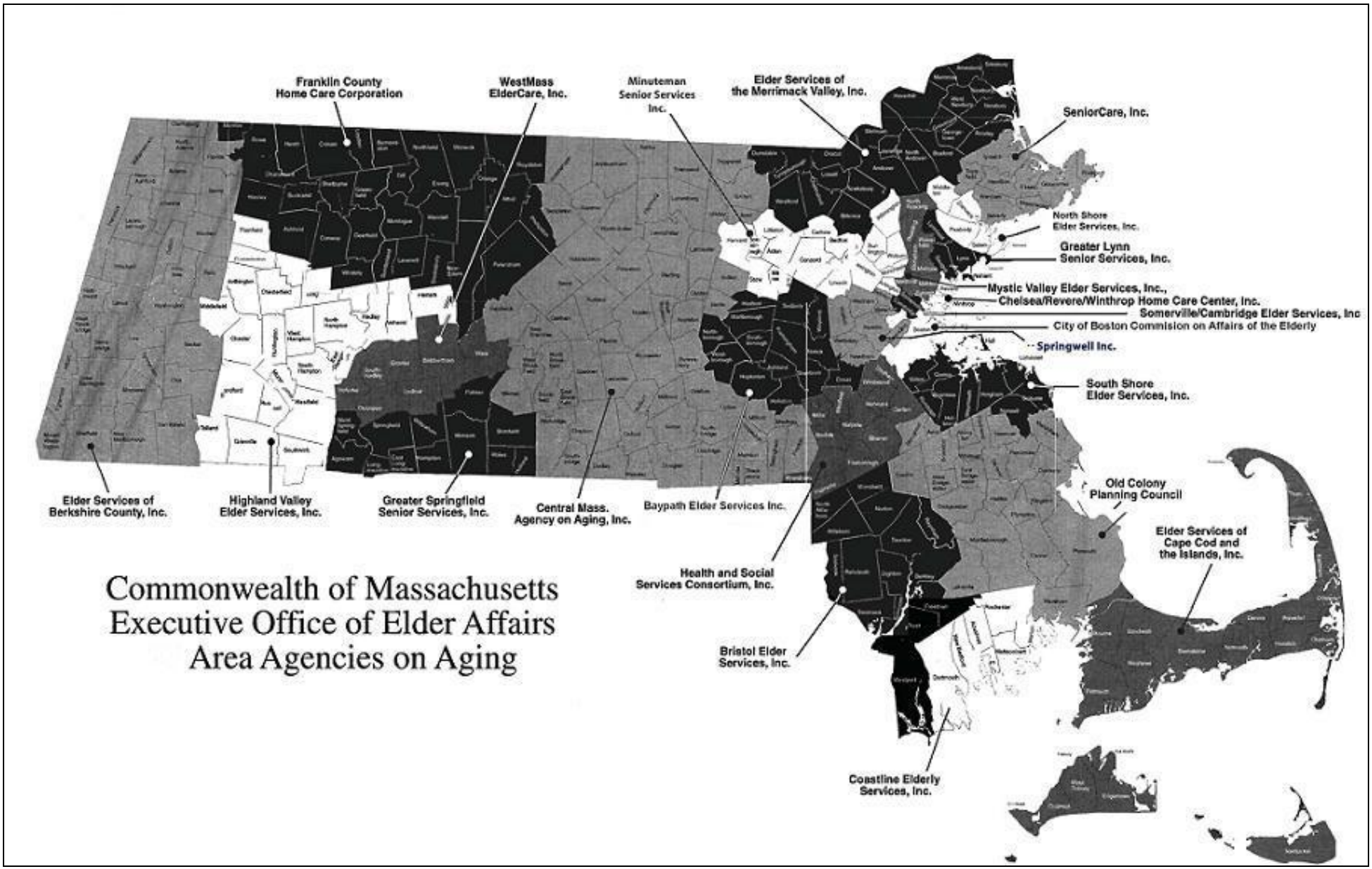
The Older Americans Act establishes a system whereby authorized program funds flow through the State Unit on Aging to Area Agencies on Aging (AAA) where they are used to support home and community-based supportive and nutrition services. In Massachusetts, there are twenty-three Area Agencies on Aging representing a like number of Planning and Service Areas (PSA). Planning and Service Areas are collections of communities that any given Area Agency on Aging serves; PSAs in Massachusetts range in size and composition from a single to city (i.e., Boston) to ones that serve over thirty cities and towns.

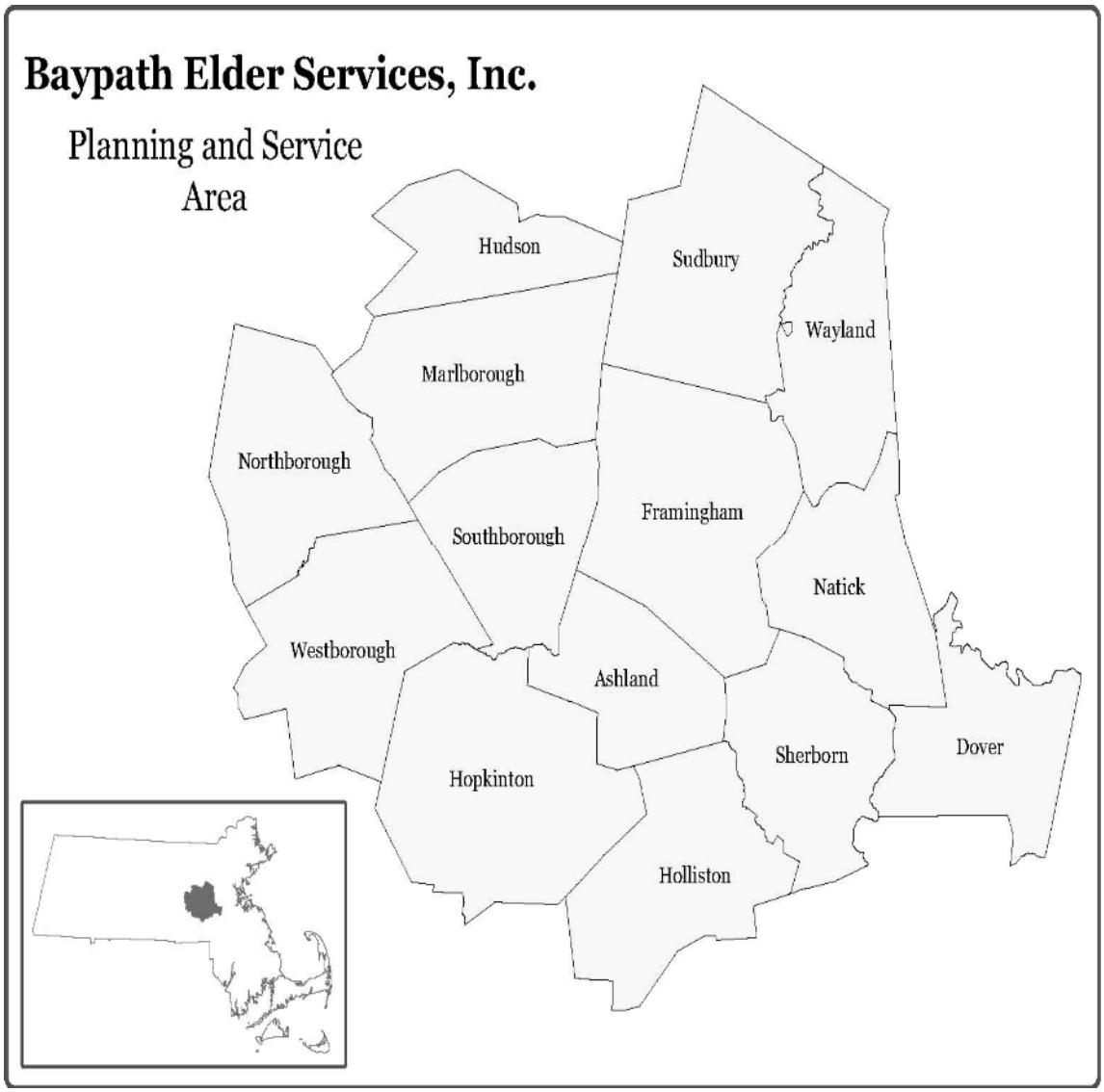
Responsibilities for overseeing Older Americans Act Programs at the Area Agencies on Aging reside with an Area Planner. Area Planners solicit and contract with private vendors for services, administer the disbursement of funding, monitor programs for regulatory compliance and maintenance of quality, and generally coordinate operation of services and resources.

Area Agencies on Aging and the Area Planners represent the original structure and system for delivering federally funded services to the elders of the nation and the Commonwealth. In Massachusetts, Area Agencies on Aging provide services in concert with another group of entities known as Aging Services Access Points, (or 'ASAPs', authorized within Section 19A of Massachusetts General Laws), which are often collocated with AAAs. ASAPs were formerly known as "Home Care Corporations", a name that spoke to their principal responsibility of operating the state-funded Home Care Program, a collection of supportive services designed to help elders remain independent and in their own homes, services that naturally complement those of the AAAs. In Massachusetts, there are 27 Aging Services Access Points, 20 of which are collocated with an Area Agency on Aging; seven ASAPs are 'stand-alone' entities, leaving three free-standing AAAs that fall outside the ASAP system.

The Massachusetts Elder Service Network includes thousands of dedicated volunteers and many public and private organizations throughout the state. Additional public and private non-profit entities contract with Elder Affairs to locally administer other service programs, including the Long Term Care Ombudsman program and the health benefits counseling program, Serving the Health Information Needs of Elders (SHINE). The network includes 349 municipal Councils on Aging and 290 senior (and drop-in) centers, nearly all of which are affiliated with Councils on Aging.

On the pages that follow is a full map of the Commonwealth with all twenty-three AAAs represented, along with individual maps of the Commonwealth's Planning and Service Areas with their parent Area Agency on Aging and, in most instances, a collocated Aging Services Access Point. Towns and cities served are named, their physical arrangement among one another shown and, finally, placed within the context of their location in the larger Commonwealth. Contact information and addresses are also included. Taken together, the maps represent graphic depiction of the elements that comprise the Elder Service Network in Massachusetts. Lastly, the seven 'stand-alone' ASAPs are detailed.


Franklin County Home Care Corporation
WestMass ElderCare, Inc.
Minuteman Senior Services Inc.
Elder Services of the Merrimack Valley, Inc.
SeniorCare, Inc.
North Shore Elder Services, Inc.
Greater Lynn Senior Services, Inc.
Mystic Valley Elder Services, Inc.,
Chelsea/Revere/Winthrop Home Care Center, Inc.
Somerville/Cambridge Elder Services, Inc
City of Boston Commision on Affairs of the Elderly
Springwell Inc.
South Shore Elder Services, Inc.
Old Colony Planning Council
Elder Services of Cape Cod and the Islands, Inc.
Elder Services of Berkshire County, Inc.
Highland Valley Elder Services, Inc.
Greater Springfield Senior Services, Inc.
Central Mass. Agency on Aging, Inc.
Baypath Elder Services Inc.
Health and Social Services Consortium, Inc.
Bristol Elder Services, Inc.
Coastline Elderly Services, Inc.
Commonwealth of Massachusetts
Executive Office of Elder Affairs
Area Agencies on Aging



Baypath Elder Services, Inc.
Area Agency on Aging/Aging Services Access Point

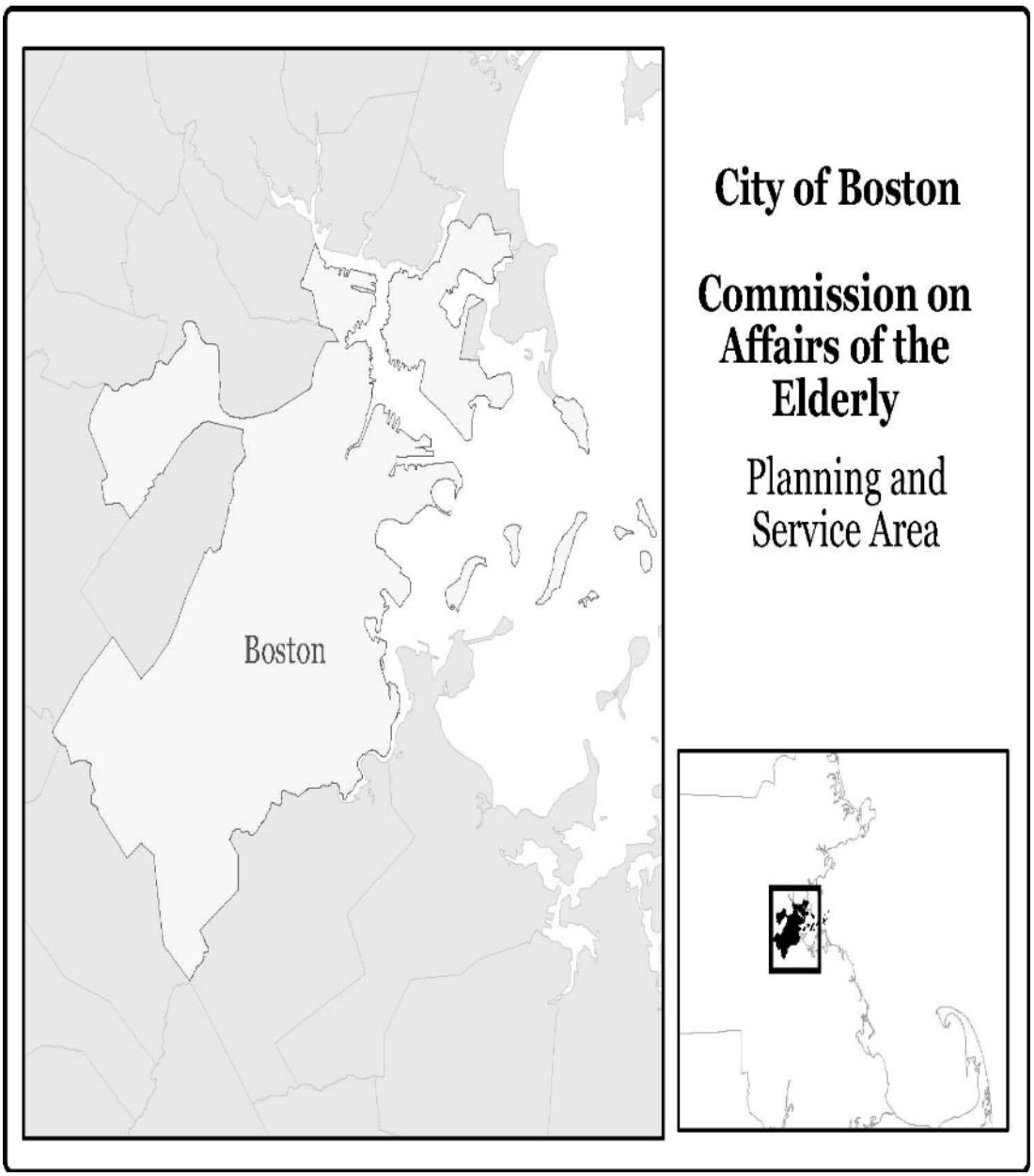
33 Boston Post Road West
Marlborough, MA 01752

508-573-7200
FAX: 508-573-7222
TTY: 508-573-7282

Elder Services of Berkshire County, Inc.
Area Agency on Aging/Aging Services Access Point

66 Wendell Avenue
Pittsfield, MA 01201

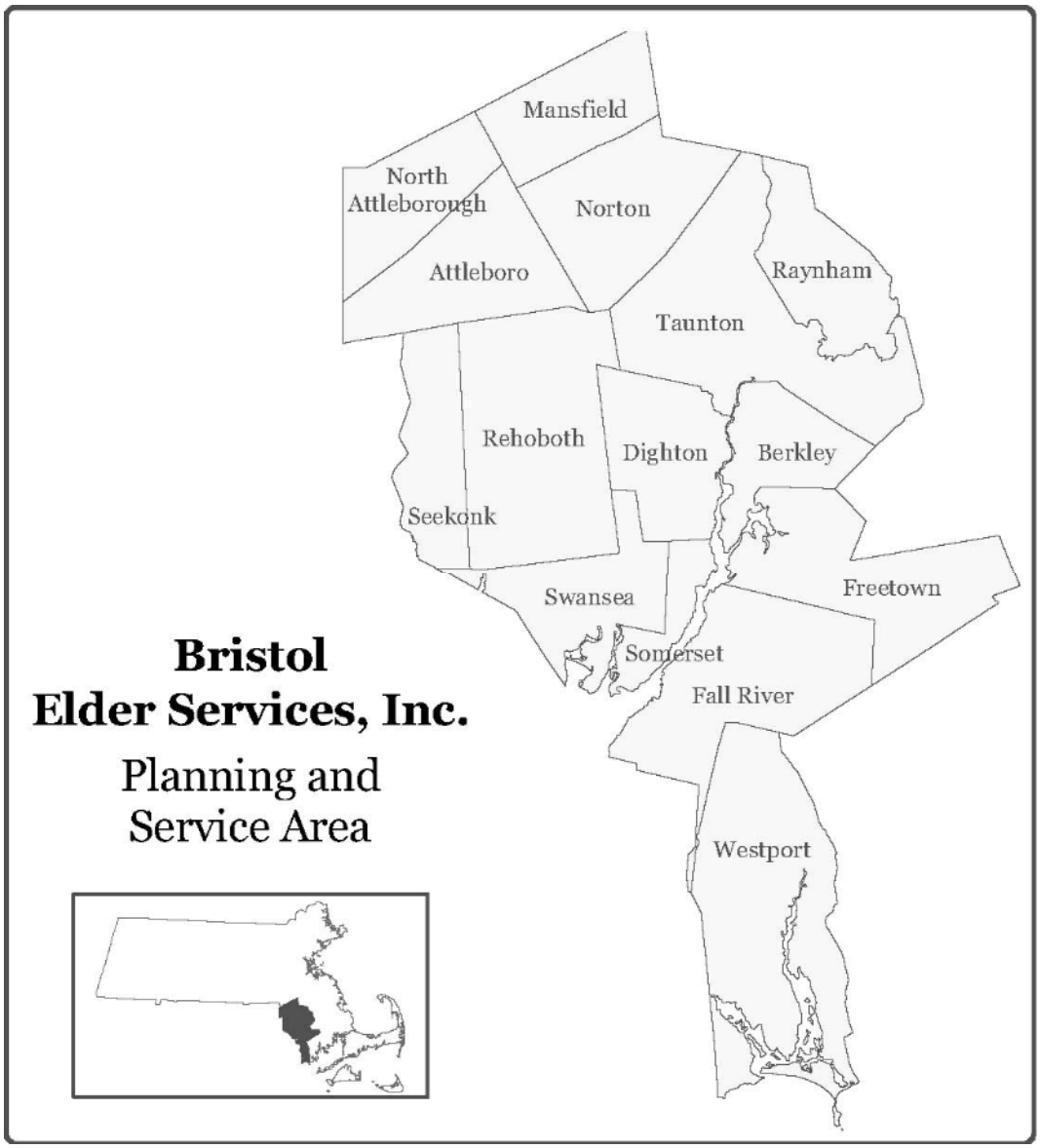
413-499-0524
FAX: 413-442-6443
TTY: 413-499-9764



City of Boston, Commission on Affairs of the Elderly
Area Agency on Aging

Boston City Hall
One City Hall Plaza, Room 271
Boston, MA 02201

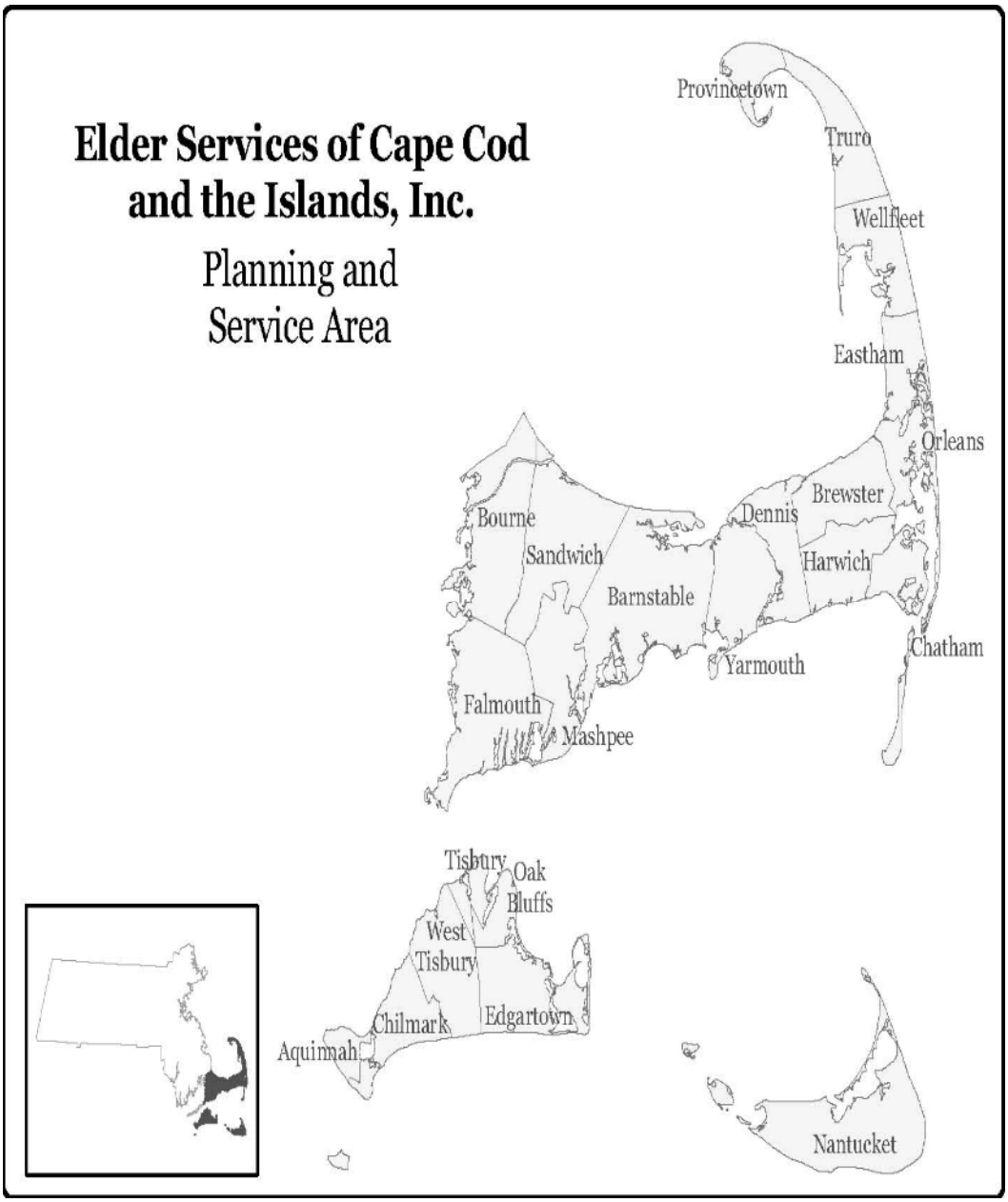
617-635-4366
FAX: 617-635-3213
TTY: 617-635-4599



Bristol Elder Services, Inc.
Area Agency on Aging/Aging Services Access Point

One Father DeValles Blvd, Unit #8
Fall River, MA 02723

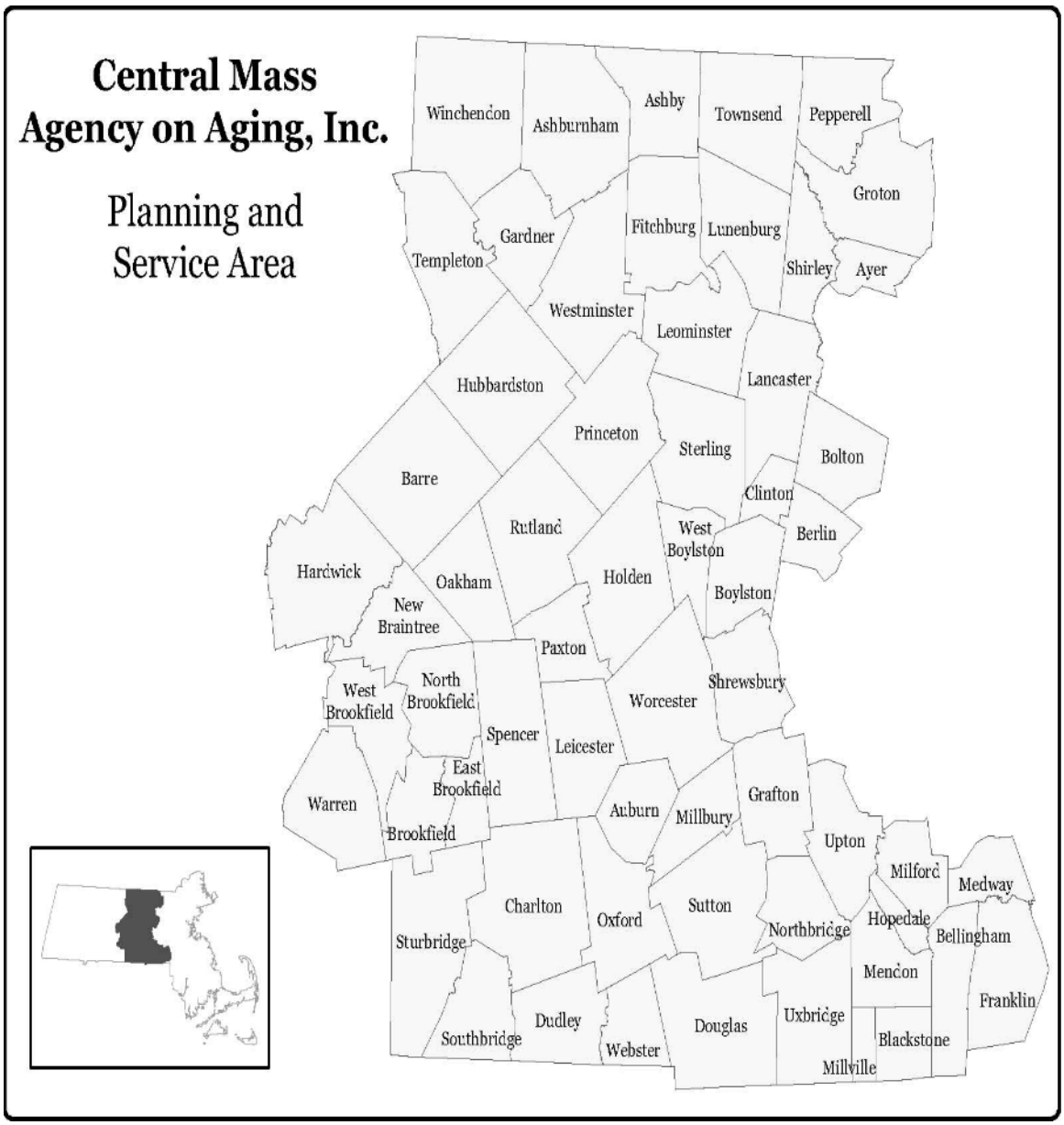
508-675-2101
FAX: 508-679-0320
TTY: 508-646-9704



Elder Services of Cape Cod and the Islands, Inc.
Area Agency on Aging/Aging Services Access Point

68 Route 134
South Dennis, MA 02660

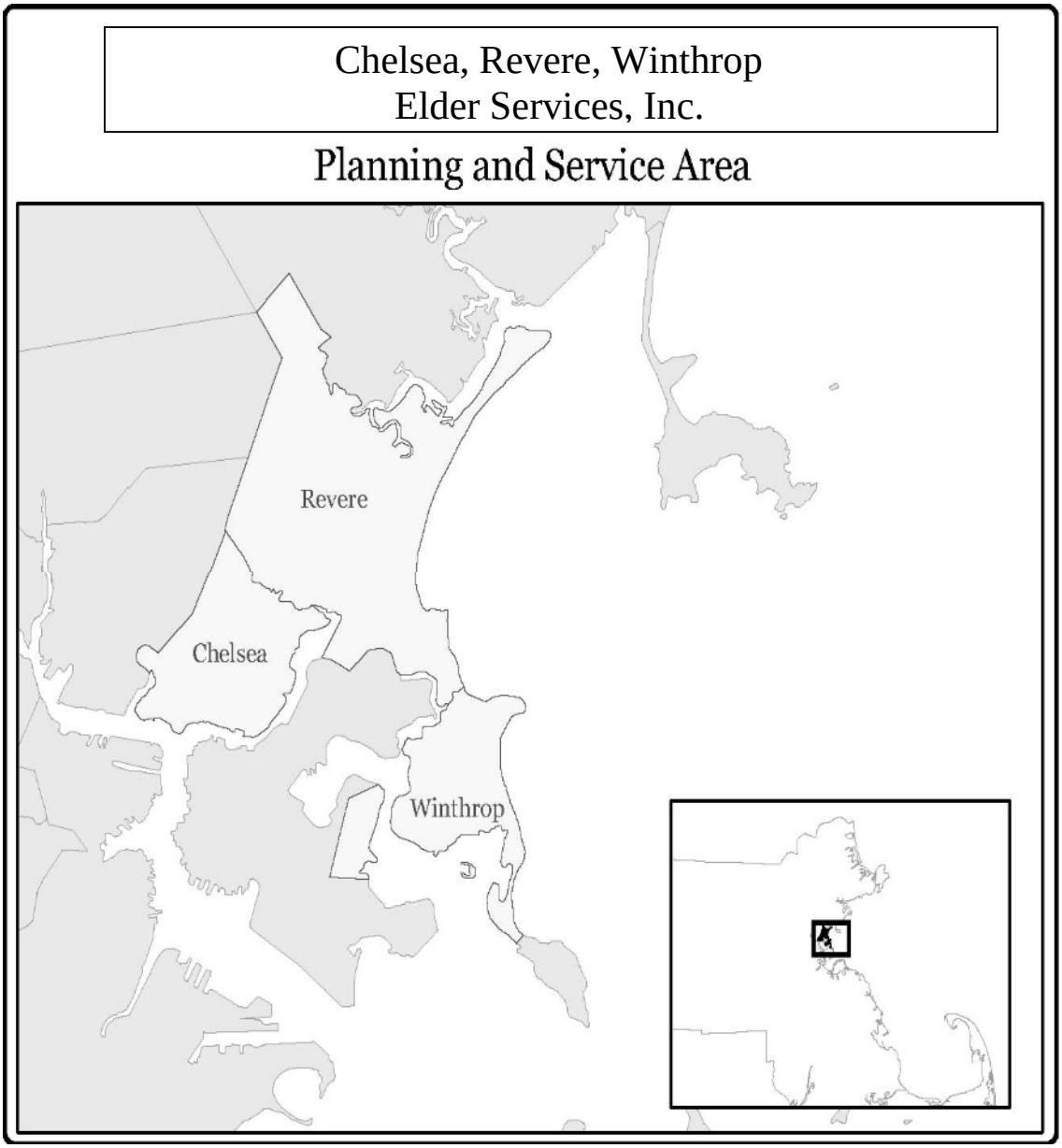
508-394-4630
FAX: 508-394-3712
TTY: 508-394-8691



Central Massachusetts Agency on Aging
Area Agency on Aging

360 West Boylston Street
West Boylston, MA 01583

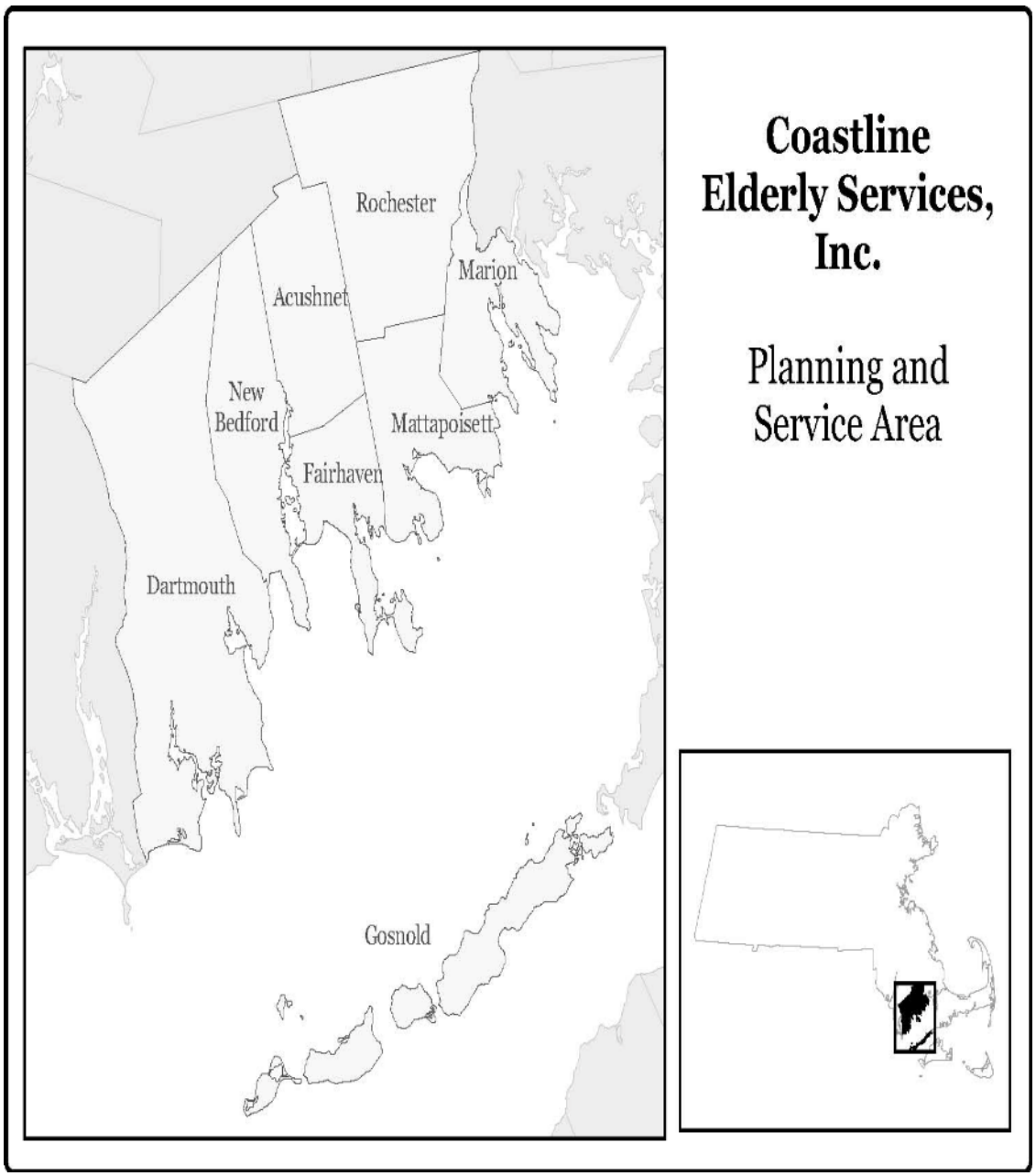
508-852-5539
FAX: 508-852-5425
TDD: 508-852-5539



Chelsea/Revere/Winthrop Elder Services, Inc.
Area Agency on Aging/Aging Services Access Services

100 Everett Avenue
Chelsea, MA 02150

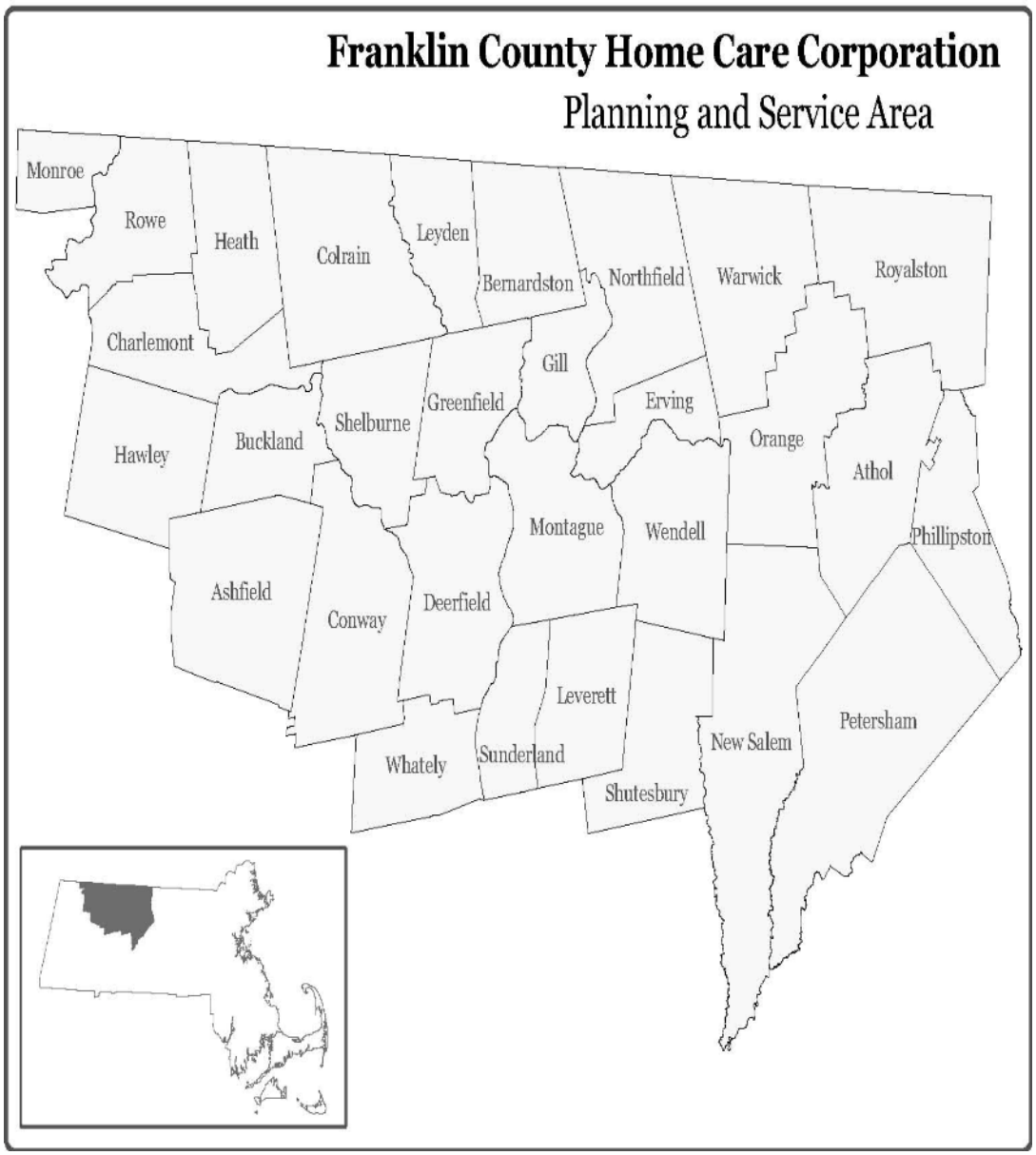
671-884-2500
FAX: 617-884-7988
TTY: 617-695-0437



Coastline Elderly Services, Inc.
Area Agency on Aging/Aging Services Access Point

1646 Purchase Street
New Bedford, MA 02740

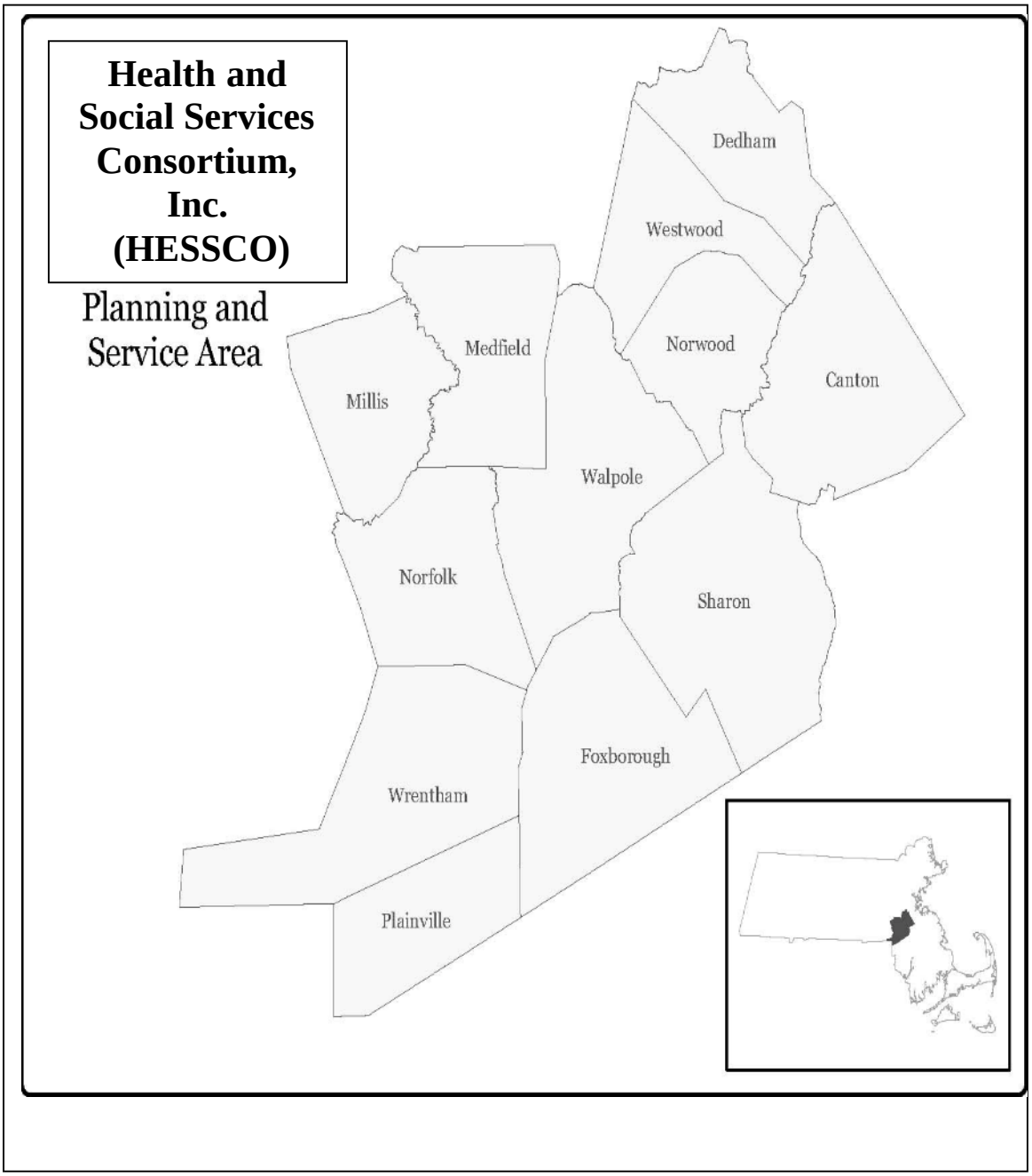
508-999-6400
FAX: 508-993-6510
TDD: 508-994-4265



Franklin County Home Care Corporation
Area Agency on Aging/Aging Services Access Point

330 Montague City Road, Suite # 1
Turner Falls, MA 01376

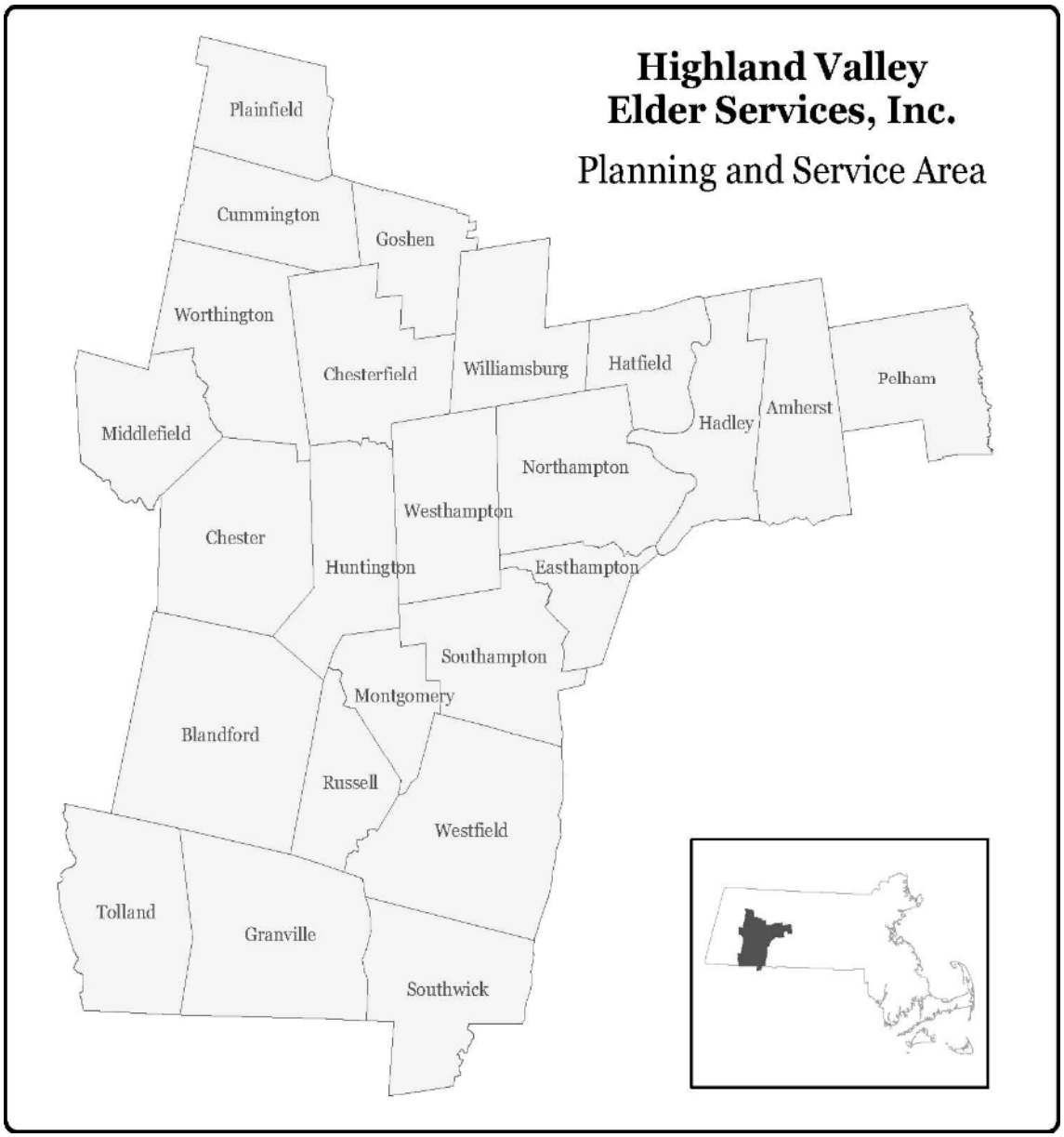
800-732-4636
FAX: 413-772-1084
TDD: 413-772-6566



Health and Social Services Consortium, Inc. (HESSCO)
Area Agency on Aging/Aging Services Access Point

One Merchant Street
Sharon, MA 02067

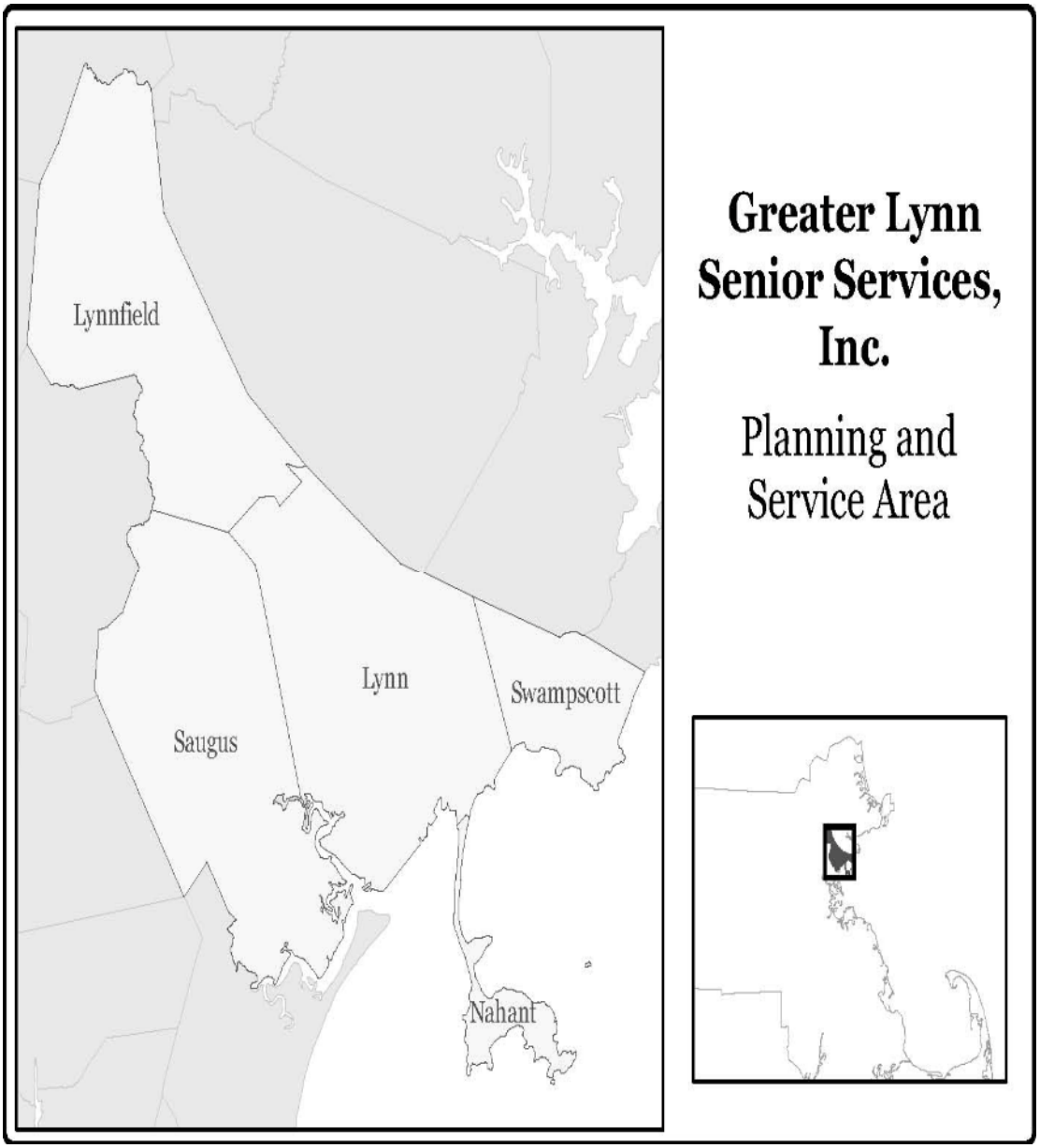
800-462-5221
FAX: 781-784-4922
TTY: 781-784-4944



Highland Valley Elder Services, Inc.
Area Agency on Aging/Aging Services Access Point

320 Riverside Drive, Suite B
Florence, MA 01062

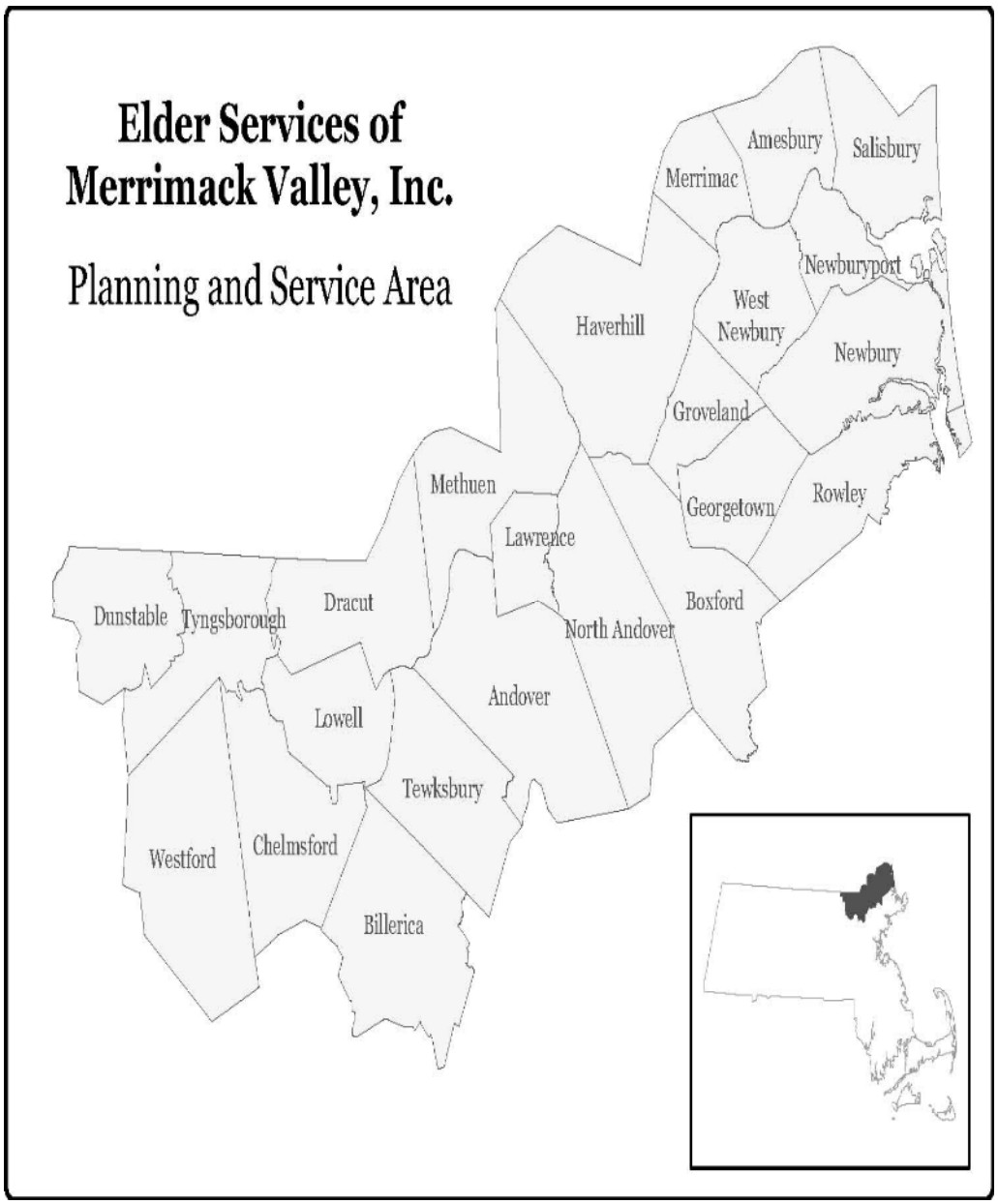
800-322-0551
FAX: 413-584-7076
TDD: 413-585-8160



Greater Lynn Senior Services, Inc.
Area Agency on Aging/Aging Services Access Point

Eight Silsbee Street
Lynn, MA 01901

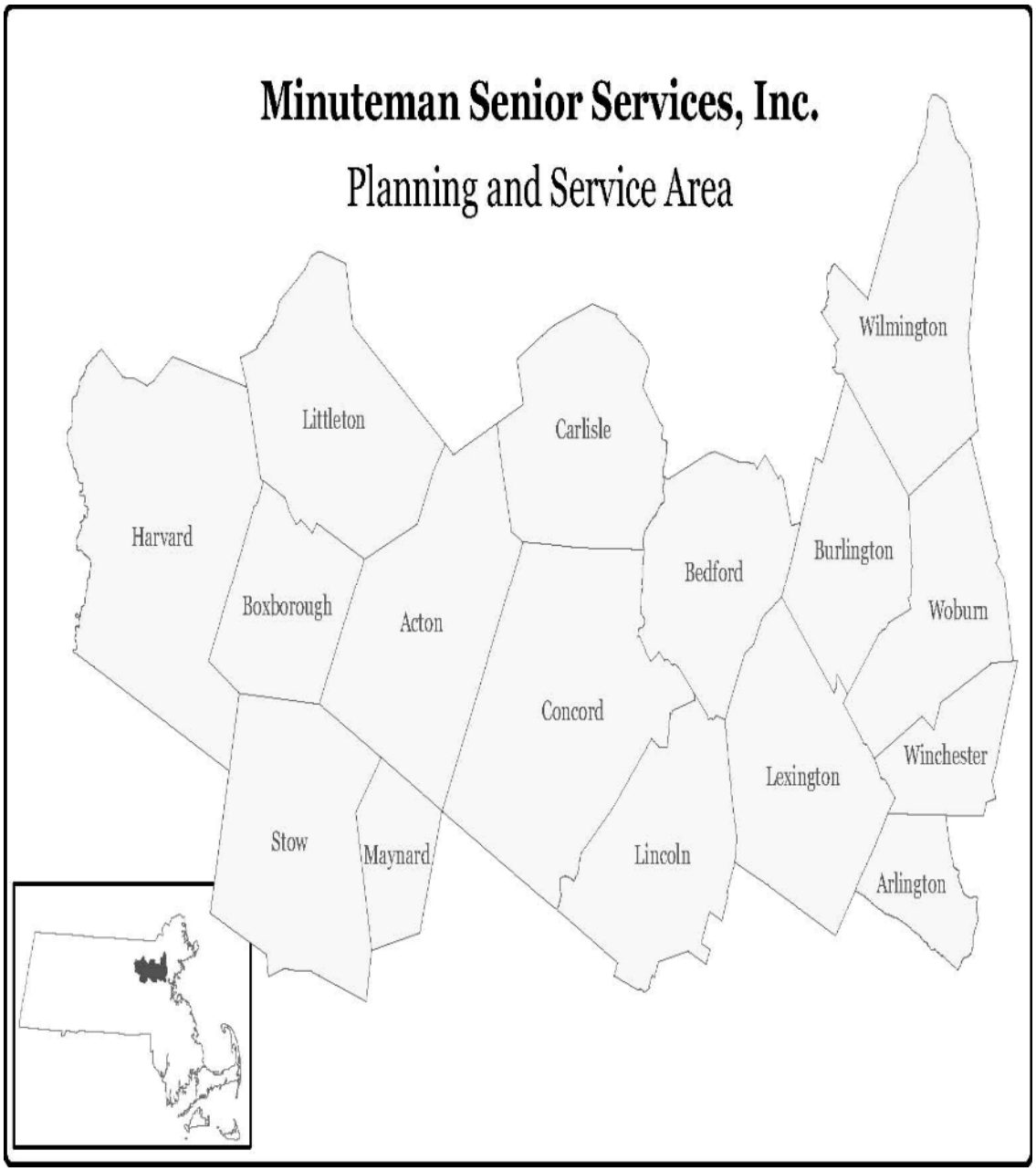
781-599-0110
FAX: 781-592-7540
TDD: 781-477-9632



Elder Services of Merrimack Valley, Inc.
Area Agency on Aging/Aging Services Access Point

360 Merrimack Street, Bldg #5
Lawrence, MA 01843

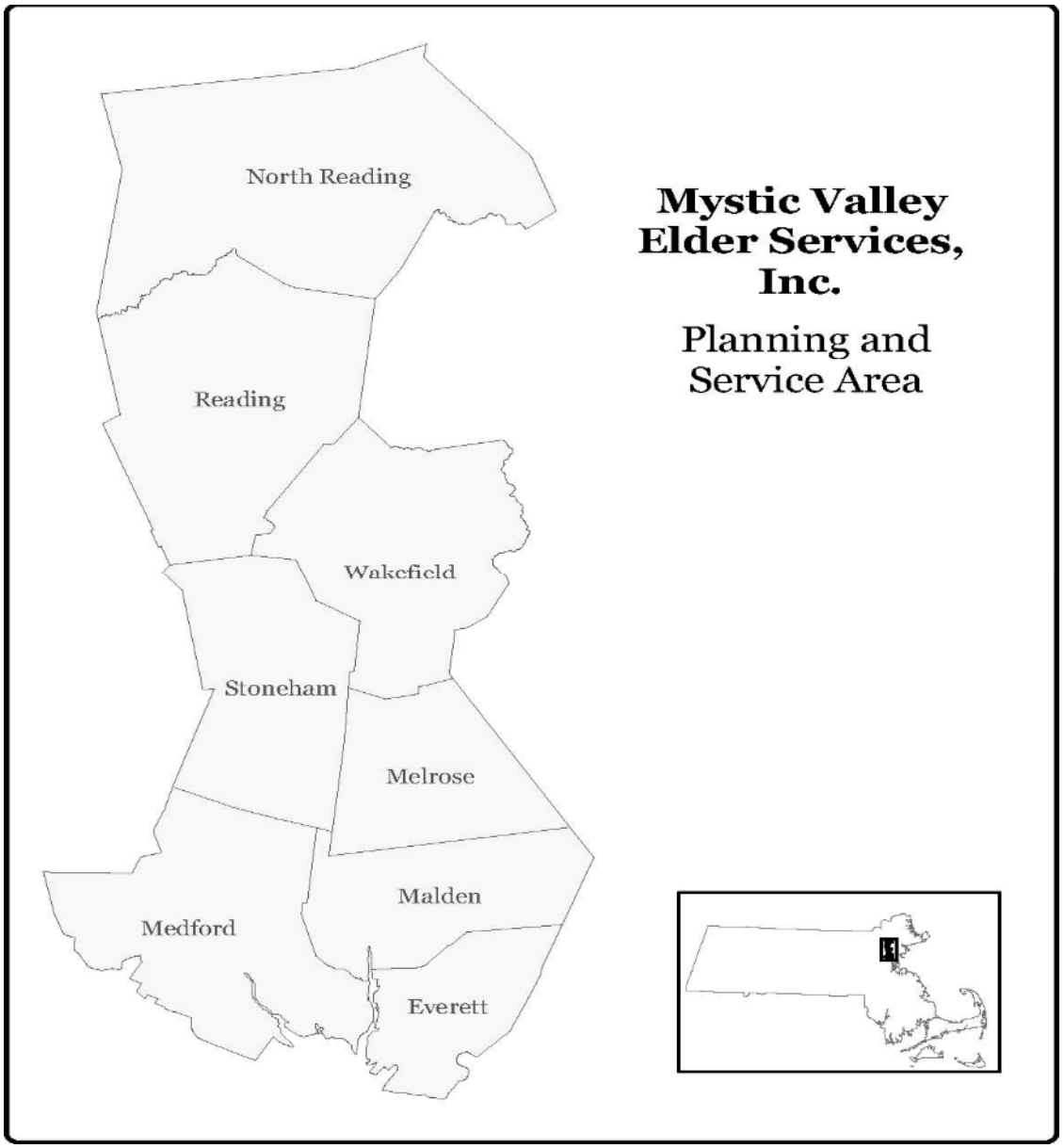
800-892-0890
FAX: 978-687-1067
TDD: 800-924-4222



Minuteman Senior Services, Inc.
Area Agency on Aging/Aging Services Access Point

24 Third Avenue
Burlington, MA 01803

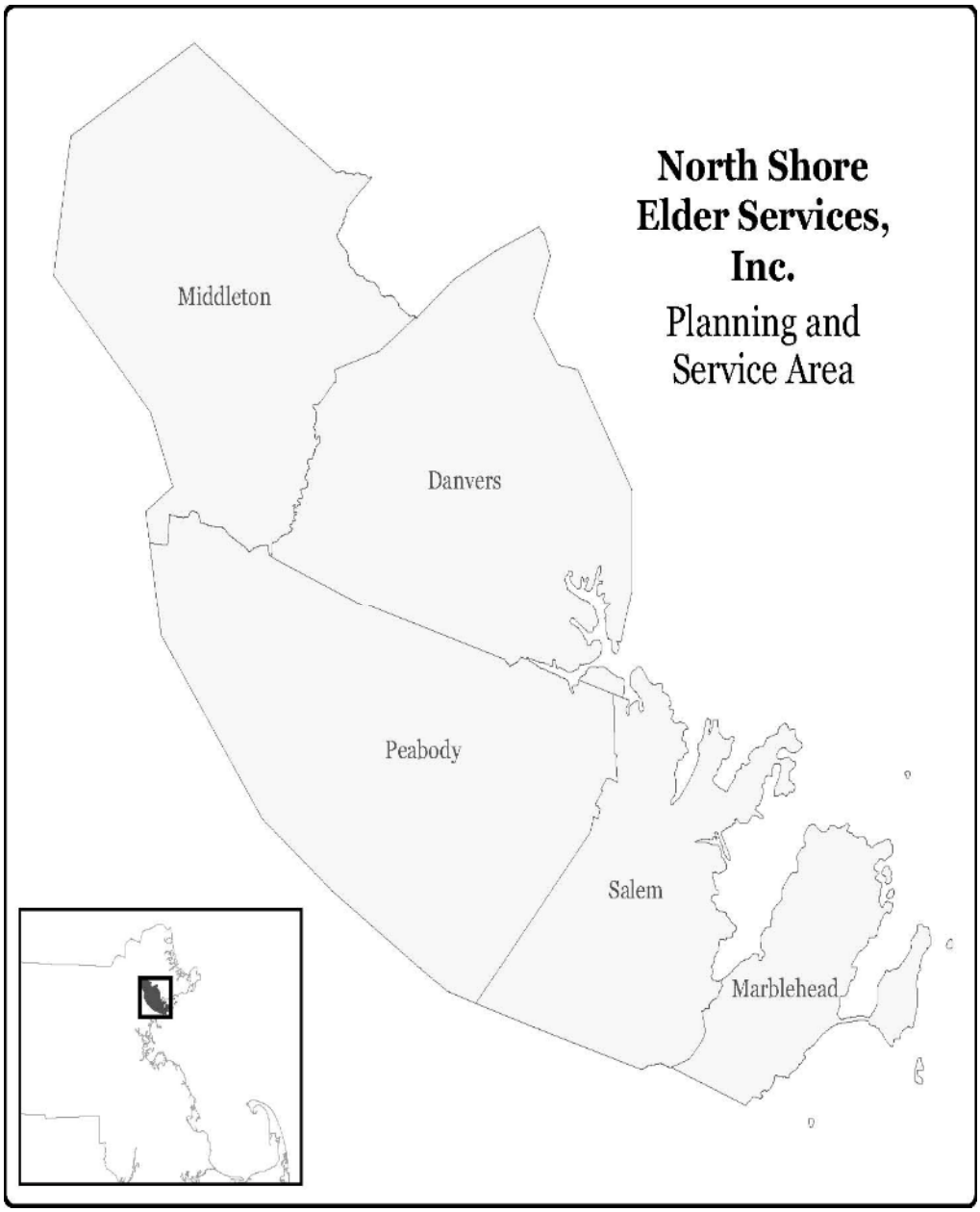
781-272-7177
FAX: 781-229-6190
TDD: 617-272-3114



Mystic Valley Elder Services, Inc.
Area Agency on Aging/Aging Services Access Point

19 Riverview Business Park
300 Commercial Street
Malden, MA 02148

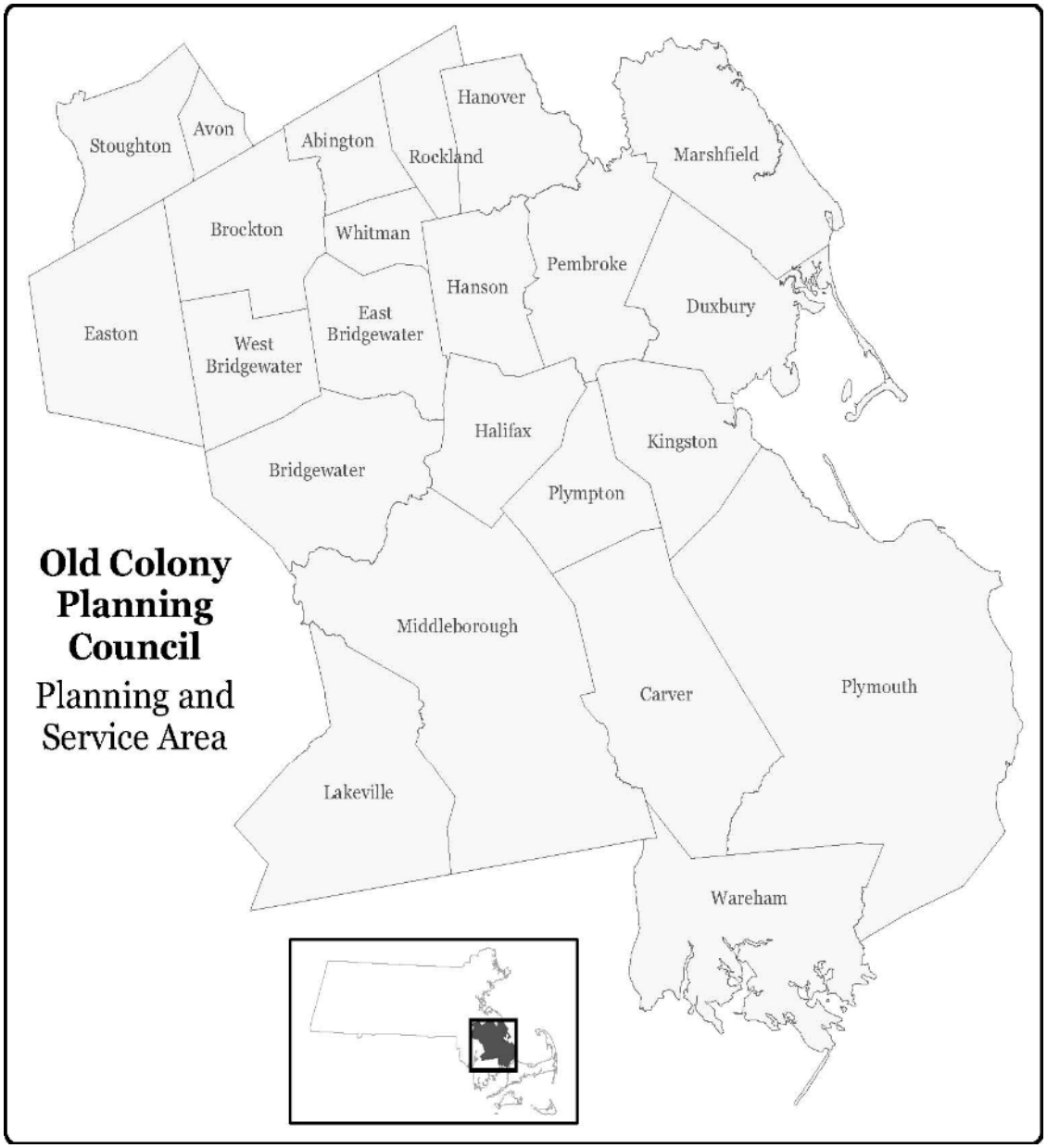
781-324-7705
FAX: 781-324-1369
TDD: 781-321-8880



North Shore Elder Services, Inc.
Area Agency on Aging/Aging Services Access Point

152 Sylvan Street
Danvers, MA 01923

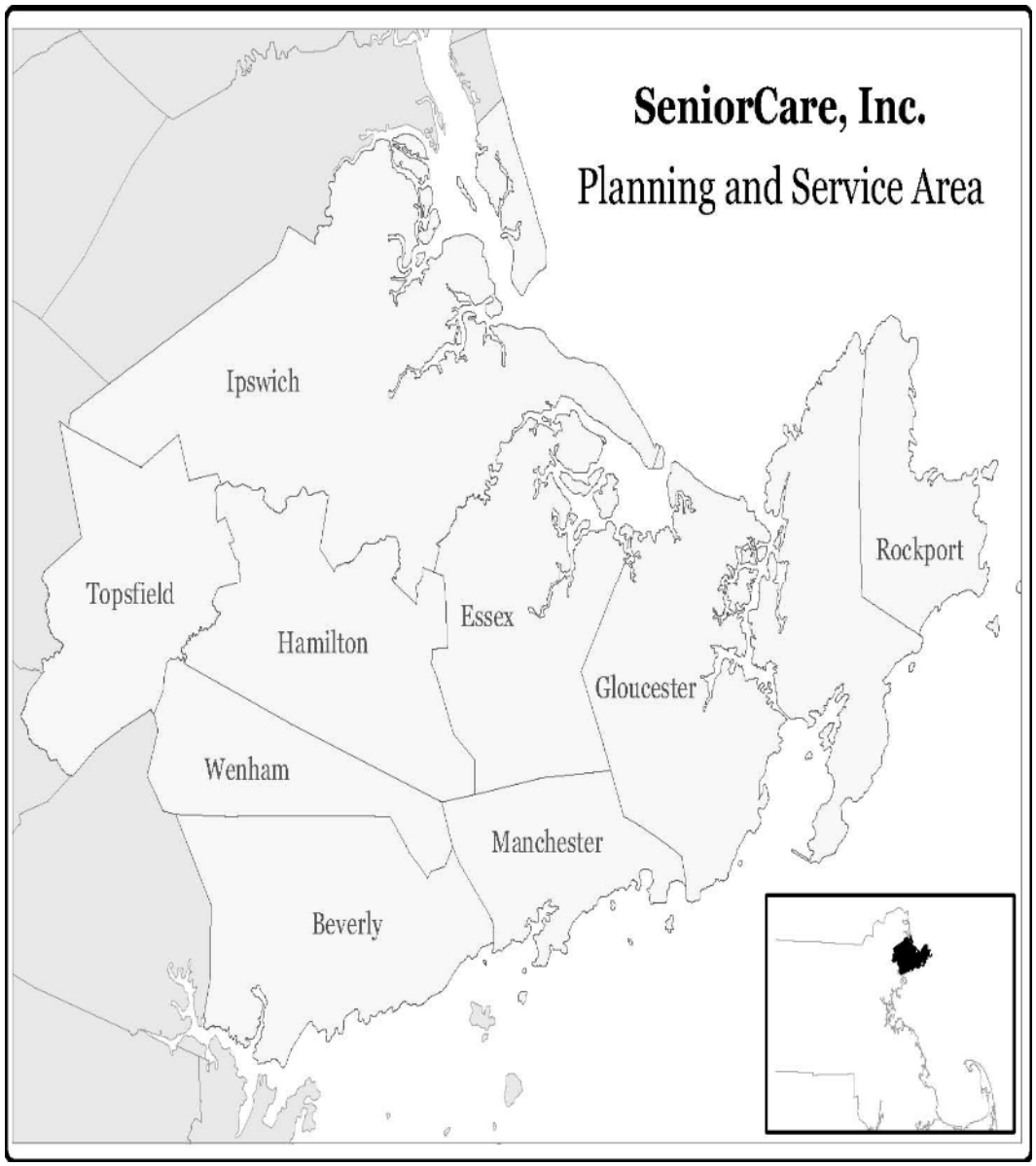
978-750-4540
FAX: 978-750-8053
TDD: 978-624-2244



Old Colony Planning Council
Area Agency on Aging

70 School Street
Brockton, MA 02301

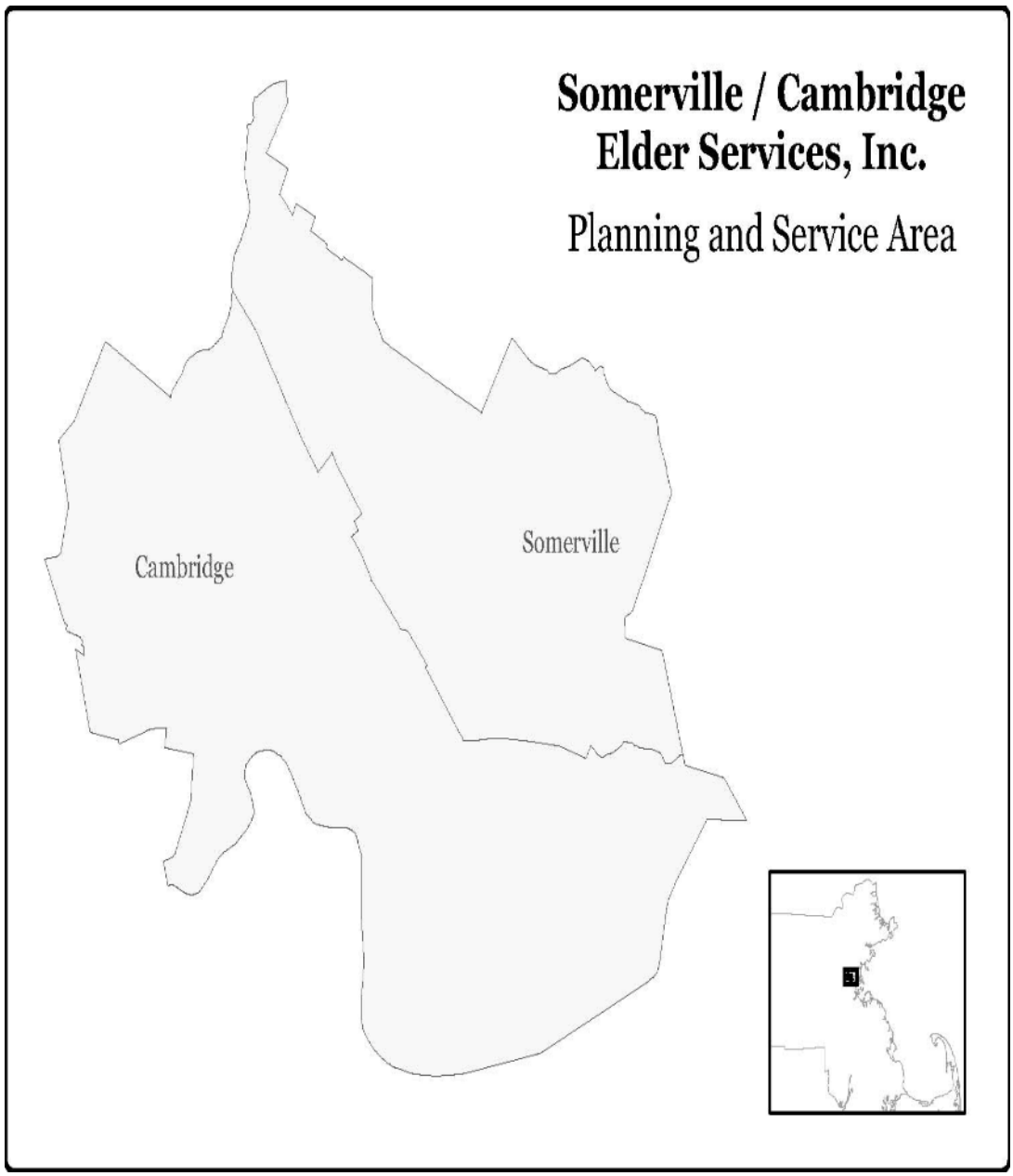
508-583-1833
FAX: 508-559-8768
TTY: 508-559-8768



SeniorCare, Inc.
Area Agency on Aging/Aging Services Access Point

Five Blackburn Center
Gloucester, MA 01930

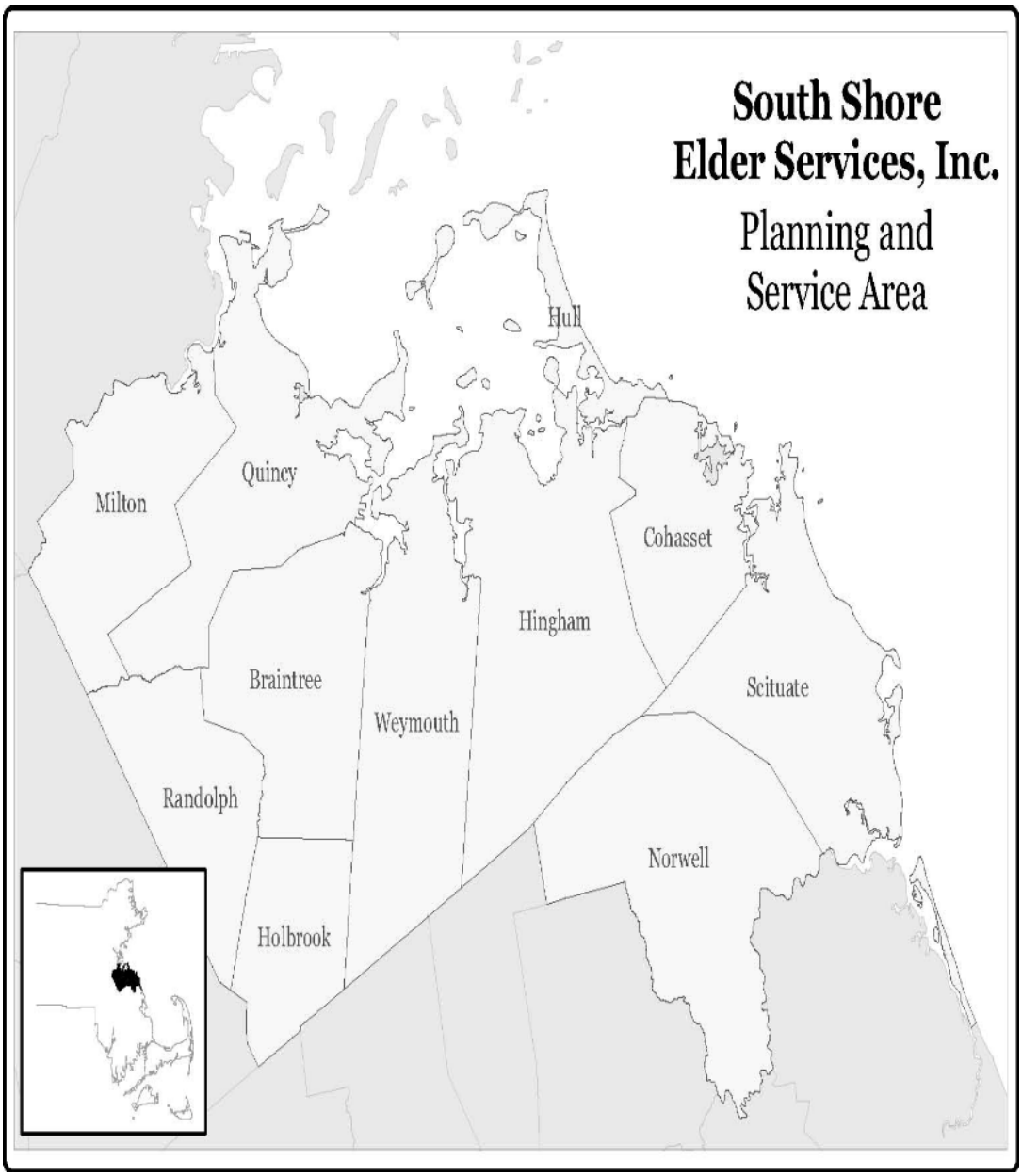
978-281-1750
FAX: 978-281-1753
TDD: 978-468-1193



Somerville/Cambridge Elder Services, Inc.
Area Agency on Aging/Aging Services Access Point

61 Medford Street
Somerville, MA 02143

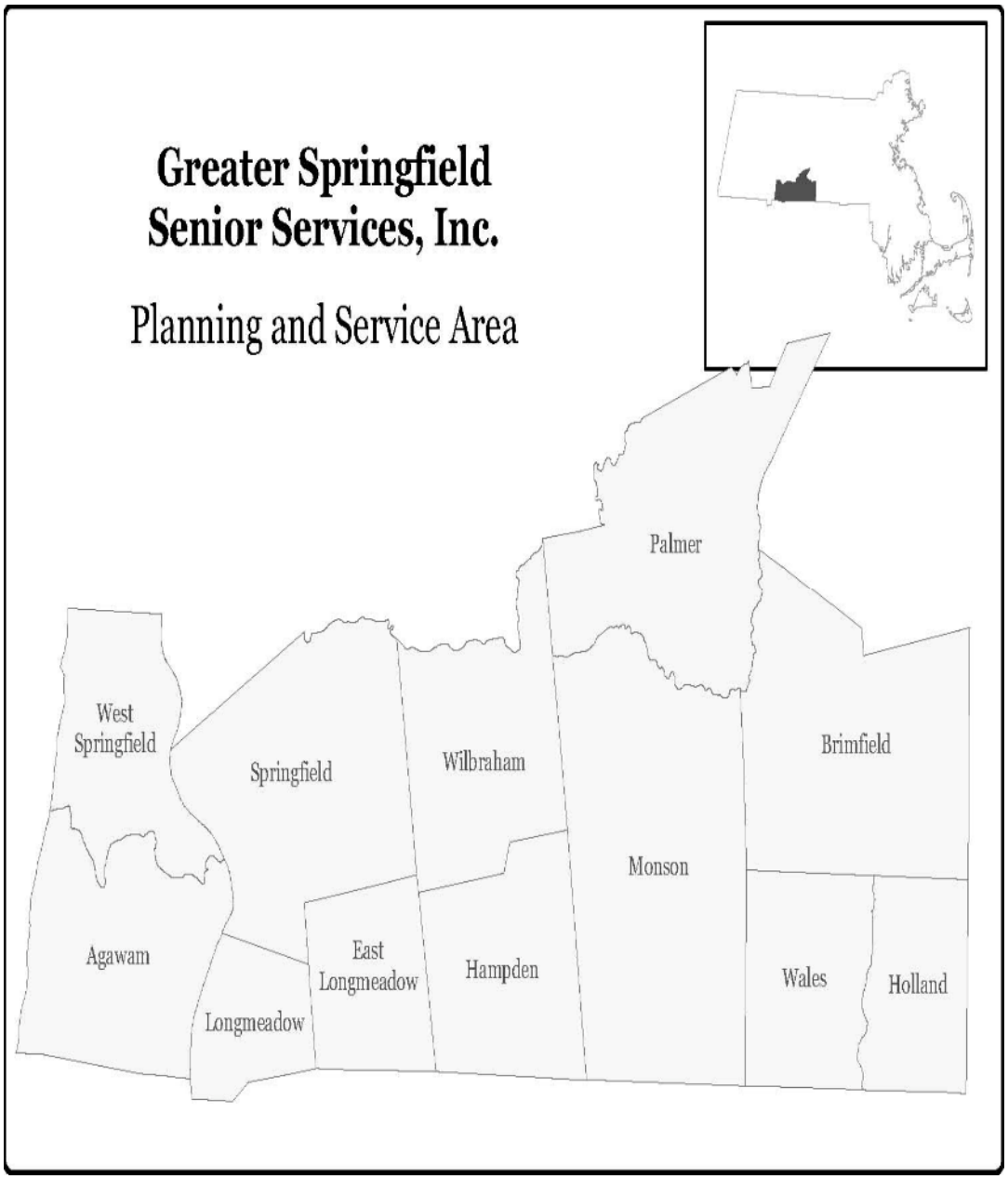
617-628-2601
FAX: 617-628-1085
TDD: 617-628-1705



South Shore Elder Services, Inc.
Area Agency on Aging/Aging Services Access Point

159 Bay State Drive
Braintree, MA 02184

781-848-3910
FAX: 781-843-8279
TDD: 781-356-1992



Greater Springfield Senior Services, Inc.
Area Agency on Aging/Aging Services Access Point

66 Industry Avenue, Suite #9
Springfield, MA 01104

413-781-8800
FAX: 413-781-0632
TDD: 413-272-0399

Springwell, Inc.
Area Aging on Aging/Aging Services Access Point

125 Walnut Street
Watertown, MA 02472

617-926-4100
FAX: 617-926-9897
TDD: 617-926-5717

WestMass ElderCare, Inc.
Area Agency on Aging/Aging Services Access Point

Four Valley Mill Road
Holyoke, MA 01040

413-538-9020
FAX: 413-538-6258
TDD: 800-462-2301

Aging Services Access Points

Listed below are the seven Aging Services Access Points (ASAPs) that do not share physical location with one of the state's twenty-three Area Agencies on Aging. They nonetheless cooperate with that Area Agency on Aging that is geographically proximate. The ASAPs are:

ETHOS
555 Amory Street
Jamaica Plain, MA 02130
(617) 522-6700

Central Boston Elder Services
2315 Washington Street
Boston, MA 02119
(617) 277-7416

Boston Senior Home Care
Lincoln Plaza, Suite 501
89 South Street
Boston, MA 02111
(617) 451-6400

Tri-Valley Elder Services, Inc.
10 Mill Street
Dudley, MA 01571
(508) 949-6640

Montachusett Home Care Corp.
Crossroads Office Park
680 Mechanic Street—Suite #120
Leominster, MA 01453
(978) 537-7411

Elder Services of Worcester Area, Inc.
411 Chandler Street
Worcester, MA 01602
(508) 756-1545

Old Colony Elderly Services, Inc.
144 Main Street, P.O. Box 4469-02303
Brockton, MA 02301
(508) 584-1561

The Boston ASAPs - ETHOS, Central Boston Elder Services and Boston Senior Home Care - work closely with the City of Boston Commission on Affairs of the Elderly Area Agency on Aging. The three ASAPs in central Massachusetts, Tri-Valley Elder Services, Montachusett Home Care Corp., and Elder Services of Worcester Area receive support and cooperation from Central Mass Area Agency on Aging in West Boylston. While the final ASAP, Old Colony Elderly Services, collaborates with Old Colony Planning Council Area Agency on Aging.